



LEEDS UNIVERSITY LIBRARY

Classmark:

Special Collections

Health Sciences Historical Collection

SC2

HUT



30106016129883



Digitized by the Internet Archive
in 2015

https://archive.org/details/b21522716_0003

THE POLYCLINIC

BEING THE JOURNAL OF THE

MEDICAL GRADUATES' COLLEGE

*PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION OF
THE MUSEUM AND LIBRARY COMMITTEE*

BY

JONATHAN HUTCHINSON

VOL. III.

JULY TO DECEMBER, 1900

London :

JOHN BALE, SONS AND DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, W.

—
1900

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. III., No. 7.—JULY, 1900.

ERYSIPELAS AND "THE ROSE."

DIVERS questions, not only of speculative but of great clinical interest, suggest themselves in connection with the word Erysipelas. The observer knows well the features of the inflammation of the skin to which he gives this name, and they are perfectly characteristic. When the skin is of a bright red and a little swollen so that it pits under the finger, the redness having an abrupt border which rapidly extends and as rapidly fades from the part just occupied, we say with confidence "this is Erysipelas." There may or there may not be seen delicate vesications over the reddened surface; these are not essential although very usual. That there is in all cases some tendency to effusion beneath the epidermis will be subsequently made evident by the peeling, or desquamation, of the latter. Now, to this clinical appreciation of the characters of erysipelatous inflammation, experimentalists have added the knowledge that the phenomena may be induced artificially, and that a certain bacillus may be isolated the presence of which, in the lymph-spaces of the skin, is their efficient cause. That erysipelatous inflammation is very contagious, that it has a very short period of incubation, and that it is very apt to be initiated by wounds, were facts which had been long familiar to the clinicist.

He knew also that the local process was often preceded by a rigor, was always attended by fever, and was never long persistent. The presence of a particulate contagium had been inferred with confidence long before Fehleisen made it a matter of demonstration. The discovery of the streptococcus gave precision to our knowledge, but nothing more, and it is possible that in some ways and for a time it crippled and narrowed our conceptions of what Erysipelas may include. It was hastily assumed by some that what resulted from a careful inoculation of a pure culture of the *S. erypelatosus*, that and that only should receive the name. Now the practical surgeon had long recognised that there were other types of inflammation which did not closely conform to this simple one which were yet essentially of an erysipelatos character, and he inferred that the contagium, which he felt sure must exist, was susceptible of modifications in its mode of life or might perhaps enter into intimate partnership with others. Fehleisen himself would much like to claim absolute specificity for his micrococcus and its effects, but as regards this he is not supported by clinical observations nor perhaps by the investigations of more recent bacteriologists. The latter, amongst whom may be mentioned Sabaurand, incline to assert that the streptococcus of Fehleisen may be influentially present in different types of inflammation, some of them not at all resembling erysipelas. It may be suitable here to suggest that the old name of "The Rose" might be conveniently kept for the Fehleisen type of erysipelas—one attended by redness and œdema only, and never by suppuration or other complications.

It is then around "*The Rose*" as the type form of erysipelas—that which results from inoculation of a pure cultivation—that the questions in debate as to the nature and limits of this malady cluster. In order to avoid prolixity we will state a few of them in detached form.

(1) There are certain facts which would imply that the specific bacillus of the Rose having once obtained access to the tissues never afterwards leaves them, but remains in symbiotic union with them, although often manifesting no obvious results. Surgeons tell us that if a patient who has once had erysipelas be submitted to an operation or receive a wound it is very likely that erysipelas will

occur again. It is acknowledged that Listerian precautions, however carefully carried out, will not in all persons prevent the occurrence of cutaneous erysipelas, a fact strongly suggestive of the possible pre-existence of the micrococcus in the tissues.

(2) In close connection with what has just been advanced, many persons after an attack of erysipelas remain liable to frequent recurrences of it. These are especially seen after erysipelas of the head and face.

(3) There is a peculiar form of solid œdema of the cheeks, eyelids and lips, which is preceded and apparently caused by frequently recurring slight attacks of the Rose.

(4) In many, indeed most, cases of elephantoid hypertrophy of limbs (Elephantiasis) the starting point is an attack of dermatitis not distinguishable from the Rose, and the same continues to recur with almost exact periodicity. Each attack causes redness and swelling, and after each the residuary œdema is increased. With each there is fever, &c., just as in Rose.

(5) It has been observed that patients suffering from lupus are prone to be attacked by the Rose, and may have recurring attacks. In lupus vulgaris the adventitious inflammation may much benefit the lupus, but in lupus erythematosus the extension may be great and the attack may end fatally.

(6) It has also been observed in Leprosy Asylums that the patients are very liable to attacks of erysipelas, and the same remark perhaps extends to all institutions in which sick persons with chronic inflammations of any kind are congregated.

(7) In certain forms of Eczematous dermatitis, when congregated in hospitals, and especially in hot weather, the disease may become contagious, and its attacks assume most of the features of the Rose.

(8) The occurrence of the Rose after vaccination is very common. The older writers used the term very freely, and thought that "erysipelas around the wound" was almost a natural sequel of the operation. Any form of dermatitis definitely of that nature is fortunately now rare, but we still recognise two forms of it, one in which the poison is introduced at the time, and the other in which it gains access to the wound after an interval. Now and then erysipelatous affections after vaccination occur as an epidemic, and

evidently spread by contagion, but in a great majority of cases no source of infection can be traced and no others follow.

(9) There occur now and then in connection with vaccination epidemics of a very contagious dermatitis characterised by vesications or small bullæ, but not by the phenomena of Rose. The hands of the operator or of the nurses appear to carry the contagion, which is apparently a very subtle one. These cases are not attended by any danger and are but slightly febrile. They have been called Pemphigus of Infants by some, and by others Contagious Impetigo. According to the recent researches of Sabaurand they are caused by the micrococcus of Fehleisen. When once an epidemic has commenced it keeps true to type, and no examples of ordinary Rose are produced. The structures of the skin involved are more superficial than those engaged in Rose, and there is no œdema.

(10) If we take what has just been described as a sort of minimised form of erysipelas we are next confronted with the deeply placed inflammations which result in what has hitherto been known as phlegmonous erysipelas. Fehleisen would like to deny all associations of these with what he would call true erysipelas, and which we have designated in the previous paragraphs as Rose. But there are many clinical facts which oppose this view, and many cases might be cited which appear to serve as connecting links between the two.¹

It is obvious from the statements which we have made that there is much yet remaining upon which future bacteriological research may be expected to throw light. In the meantime it may, we think, be held probable that the older view which did not confine the term Erysipelas to typical examples of Rose was the correct one, and that in connection with Fehleisen's micrococcus a great variety of inflammations may be produced. The explanation of the differences thus assumed in connection with a common cause may perhaps be found in modifications of virulence of the coccus in connection with the tissue or the subject in which it has been bred, or they may be due to organic partnerships with other forms of algal life.

J. H.

¹ See a report of two epidemics of this eruption in "Archives of Surgery," vol. i. A portrait in the Polyclinic Museum illustrates it.

THE DANGERS OF CIRCUMCISION.

THERE is at present a movement in an influential section of London Jews to have circumcision declared to be a surgical operation. It is desired to take it wholly out of the hands of non-professional operators and confine it to those of surgeon's. The reason alleged for the proposed change is that under the present system accidents happen which sometimes even endanger life, which would be avoided if the operators were better skilled. To most of us it is probably new to hear of fatal results from infantile circumcision, for we had been accustomed to regard it as a procedure involving no sort of risk. This impression may, however, on consideration, be easily seen to have been not probably true, and we are now assured that as a matter of fact it is not so. A certain number of deaths of infants do follow the operation, and there is an impression that they have increased of late. Hence the present movement, which has also a further support in a vague idea that "antiseptic surgery" ought, in these days, to be employed.

It is not easy to get any facts as to the accidents which are suggested, and it is alleged that they are in most instances carefully concealed. Some years ago a considerable group of cases of syphilitic inoculation occurred in the practice of a professional circumcisor (not a surgeon). Several of the cases were very severe, and more than one ended in death. These lamentable results were clearly traced to the gross carelessness of the operator as regards the cleanliness of the box in which he carried his lint and instruments. He had been accustomed to put the portion of the prepuce which he had removed under the lint to be used for his next case. His chagrin was such at the extent of the calamity which he had caused that he subsequently committed suicide. No similar cases have, so far as we are aware, since occurred in London. What is at present alleged does not so much concern the risk of transmitting syphilis as danger from septic poisoning. As just remarked it is not easy to get definite facts, but it is said that recently several infants have died within a few days of the operation—with gangrene

of the skin of the penis and adjacent parts. In one of these an attack of convulsions was the immediate precursor of death. Now, the dangers which hospital experience would lead the surgeon to suppose chiefly incidental to this operation are, leaving aside syphilis, chiefly three—erysipelas, hæmorrhage, and an unhealthy state of the wound. The last of these is rather a cause of suffering and a risk as regards tuberculosis than a danger to life. It may easily be the fact that some of the cases of so-called “gangrene” and “blood-poisoning” were really of an erysipelatous nature. Hæmorrhage, a well-known risk as regards the operation when performed by house-surgeons upon out-patients, is not mentioned in connection with the Jewish infants. We are told that they never bleed and that no anxiety is entertained on that score. This freedom from risk of bleeding is no doubt due to the peculiar method which the Jew operators adopt. In common with other nations which practise this rite, they remove skin only, and do not cut mucous membrane. Above all they never touch the frænum. Their method is to draw the skin well forward into the grip of blunt blades and then to shave it off, leaving the glans still covered by a hood of mucous membrane. This latter is next torn up along the dorsum by the thumb nails and is turned over on each side and left. Thus the frænum is untouched and the incised wound is in skin only. It is, of course, from the frænum that the bleeding occurs. No sutures are ever used nor are ligatures ever thought of. In the operation as done in hospitals and on, it must be remembered, much older children, or it may be adults, it is customary to take away less skin and more mucous membrane, and often to cut the latter close to the frænum. If the latter be left it often forms an œdematous swelling which looks ugly for some months after the operation. Thus it is necessary to enjoin on the operator that he be careful to tie the frænal vessels. If he fail in this there will probably be recurring hæmorrhage within a few hours, and in the case of a delicate child it may proceed to an alarming extent or even cause death. It is quite possible that it might be well if our surgical operation were approximated more closely to that of the religious rite, and that it were customary to take the skin more freely and to spare the mucous membrane although at the cost of some loss of neatness in the immediate results.

The only precaution taken by Jewish operators which is in the least an antiseptic one is that the operator having first taken wine into his mouth subsequently sucks the infant's penis. The organ is wrapped in lint, dry or oiled, or it may be left uncovered. We are assured that the healing is usually very rapid and is complete in a few days.

There can surely be no hesitation in the professional mind as to the propriety of transferring this little operation, slight as it is, exclusively to professional hands. If this were done, and due attention to dressing, &c., thus secured, we cannot doubt that there would ensue a saving of infantile life and suffering. If this change should result ultimately in the extension of the practice, and its employment in all classes of the community it would be, we are convinced, a definite gain to the Christian race.

J. H.

REFERENCES *versus* TESTIMONIALS.

IN bygone times most medical appointments were to be gained only by the degrading, troublesome, and expensive expedient of a personal canvass. That has now happily been done away with, but there still survives the practice of printing and distributing testimonials. This practice, superseding the other, has of late assumed such dimensions that it is only in degree less expensive, troublesome, and degrading than was its predecessor. If the results of the practice were good we might make an effort to tolerate it, but no one acquainted with the details of these elections can believe that they are so. Nor is the evil confined to our own profession. During the present summer two very notable examples of the practice have come under public notice. They are only two amongst many, but yet may well serve as texts. We refer to the election of a Regius Professor of Medicine in Edinburgh, and that of Chaplain to King Edward's Schools.

It may be thought that we put a great thing by the side of a small one, but in the necessity for doing so there is a lesson for

ourselves. In the sister profession of Divinity the practice of seeking testimonials does not prevail as regards the higher offices. Would-be bishops, so far as we know, do not canvass; certainly they do not print testimonials. In the instance of the chaplaincy mentioned the extent to which this method was resorted to, although it could not rival in extent the unapproachable dimensions of what was done in Edinburgh, was yet more at variance with good taste. This was, perhaps, unavoidable, for a clergyman's qualifications are necessarily more merely personal than those of a medical professor. The latter can appeal to what he has written, and possibly to the discoveries he has made, and, although there may be in this much that should raise a blush, it is not so bad as seeking testimony to "genial manners," "moral character," and "spiritual attainments." There is something peculiarly offensive in a state of things which makes it necessary for a clergyman to ask his friends for their opinions of him in these matters and, when he has got them, to put it all into print. Apart from the descriptions of manly bearing, suavity of manner, melodious voice, and other matters, some of the qualifications adduced by these candidates might have raised a smile. It was, of course, right in connection with a school-post that athletics should not be omitted, but the emphasis given, by almost all, to feats on the cricket-field and in the swimming-bath would have astonished alike the evangelist and the pedagogue of a century ago. Nor could a candidate for such a post be blamed for stating that he was married, and that his wife was, in his opinion, well qualified as a helpmeet. It was, however, going perhaps a little too far to state, as one candidate actually did, that although not yet wedded he was engaged, to give the name of his intended bride, and to pronounce an exordium on her merits.

From lapses of good taste of the kind just mentioned we are, in the medical profession, saved by the absence of temptation, but much that is done is yet bad enough. The worst of it—or should we say the best of it?—is that all this effort is in the main useless. The reams of monotonous testimonials are either not read, or read with distaste. Of this the recent election at Edinburgh may probably be reckoned as a notable example, for if report speaks true, a candidate of vast attainments and great fame

—who ought to have trusted to his own character, the sagacity of the electors and the spontaneous good word of his friends—did himself great damage by seeking extraneous support of the kind to which we refer. Men got tired of hearing even Aristides called “the just,” and on the same principle it is quite possible to excite antagonism by the too persistent insistence on merits which yet are quite real.

Reversing what is true of deeds of mercy, the practice of giving testimonials is twice cursed. It curseth alike him that gives and him that takes. Of the giver we need say nothing, it is but too keenly felt. The injurious influence of the testimonial upon its recipient is, however, sometimes overlooked. In reality it may be terrible. A modest, plodding man, hitherto content to do his best and to act according to his nature, learns for the first time that his friends esteem him a genius, that he is a most estimable colleague, and a perfect gentleman. He goes through life thenceforth believing himself a Brodie or a Bright, his face wreathed with smiles of complacency and his conduct characterised by the self-conscious airs of a gulled Malvolio. The man has believed his own testimonials and he becomes an unbearable prig. Were it not that we have all of us gone through the process this nuisance would be yet more conspicuous than it is.

Now all this evil might be saved by a simple device. Let candidates give references but no open documents. Let nothing appear in print. Let it be the practice for the electoral board to apply privately to three or four of those whose names have been given, and there let the matter end. In this way all would be done in decent privacy, and the kind of guidance which the electors would receive would be infinitely more trustworthy than it is under the present methods.

DR. MORROW ON LEPROSY.

IN his article on Leprosy in the "Twentieth Century Cyclopædia of Medicine," Morrow writes (p. 446) :—

"While we are ignorant of the exact conditions under which the pathogenic agent of leprosy is best able to maintain and perpetuate its existence, observation shows conclusively that the surroundings which man acquires in certain localities are destructive of the microbes, while in other localities the conditions which surround man favour their preservation and propagation."

One might have expected, after such an admission, a patient and painstaking investigation as to the peculiarities of the localities in which the leprosy microbe thrives, and those which are destructive to it. Had such been attempted, it would, at any rate, have come out clearly that the conditions have nothing to do with latitude, climate, soil, or race. Dr. Morrow, however, contents himself with the assertion that the "variable virulence" of leprosy as to locality and epoch is no more remarkable than that exhibited by other diseases. He particularly instances syphilis and small-pox as contagious maladies which have had their epochs of epidemic and local prevalence. But surely the most impressive differences as regards both of these are presented by leprosy. Syphilis had its European invasion period in the last years of the fifteenth century, when it prevailed probably to a greater extent than it has ever done since; but this was because it was a new disease, spreading in a virgin soil, and one against which no precautions were taken. Since then it has prevailed precisely in ratio with the known amount of exposure to risk of contagion. There has never been the slightest mystery about it. Let Dr. Morrow point us to any country in which the contagious disease syphilis has once obtained foothold and has since died out. There is none such; but there are plenty where leprosy has come to an end. Nor, with the single exception of the Sandwich Islands, is it easy to find any instance of anything like epidemic prevalence of leprosy in modern times. That epidemic is easily explained by the advocates of the food hypothesis, for it was synchronous with the advent of the Chinese and the establishment of a fish-curing establishment. There has been but little proof of

“variable virulence” in other parts of the world. Its course has rather been of persistence in many districts, slow decline in many, and slow increase in others. In South Africa its introduction dates back nearly two centuries, and it has very slowly spread and has even now attained only to very moderate dimensions. Here again precisely the same explanation may be given as has been suggested for the Sandwich Islands. If leprosy had had its epidemics, and no other cause could be suggested, the probability of its contagiousness would be much greater than it is ; but the simple fact is that it has not had them, and that there is no justification whatever for asserting any parallelism of it with small-pox and measles.

NASAL DISCHARGES IN LEPROSY.

DR. SINCLAIR BLACK, the resident medical officer in Robben Island has recently devoted much attention to the examination of the nasal discharges in lepers. He finds that in 50 per cent. of the tuberculous cases, 30 per cent. of the mixed, and 10 per cent. of the anæsthetic, bacilli are present. “In some cases the amount of bacilli is almost incredible ; they are discharged from the nose almost as a pure culture in countless thousands.” In some anæsthetic cases of old-standing which were apparently quiescent, the bacilli have yet been found to be present and the suggestion is made that in all cases reported to be cured this mode of enquiry should be made. Dr. Black’s observations are in corroboration of those made by others and to which Dr. Morrow has in his article in the “Nineteenth Century Cyclopædia” especially asked attention. They go to support—if any support had been needed—the doctrine of identity of the two clinical forms of leprosy. Before we accept this proved presence of bacilli in the nasal discharges as implying probability that transference from one person to another may occur by the nose evidence is needed in two other directions. First it should be shown that the bacilli so shed are living and capable of producing their kind, and next that amongst those who come in

contact with lepers, nasal symptoms are apt to originate as the first stage of leprosy. On neither of these have we as yet any proof and in respect to the latter there is a great accumulation of negative facts. That nothing in the nature of aerial transference takes place is made certain by the fact that attendants in leper asylums, visitors, &c., almost never contract the disease. Opportunities for such transference have been abundantly allowed in Robben Island and no single instance even of suspicion has been observed. We are limited then to the supposition that actual inoculation by contact is necessary. Of this again we have not the slightest proof. Although catarrhal discharges and chronic rhinitis are common in leprosy no one has ever noted a primary sore on the outlets of the nostrils.

LEPER ASYLUMS REALLY PRISONS.

THAT the Cape leper asylums are really prisons rather than hospitals is made clear by many expressions in the Government Reports. There has recently been formed a second asylum for Cape Colony at Empjanyana. It is on the mainland and is viewed with less dread than is Robben Island. Deportation to the latter is a measure held out *in terrorem* over insubordinates at Empjanyana and it is recorded that after a recent insurrection six ring-leaders were arrested, conveyed under escort to Eingscobo gaol from whence they were removed a few days afterwards to Robben Island. "Since then the conduct of the patients has been better." It is stated that the conduct had previously been anything but satisfactory. "Frequent endeavours to escape were to some extent frustrated by the vigilance of the guards, but during the year (1897) twelve male and four female lepers effected their escape, of whom only six were recaptured. On one occasion, in September, a number of males taking advantage of a dark night forced open one of the gates and six of them made good their escape."

THE FISH TRADE IN NATAL.

IN reference to the recent development of leprosy in the Colony of Natal it becomes of importance to enquire as to any changes which may have taken place in dietetic habits. Until quite recently there were no fishing establishments on the coast and the original inhabitants, Kafirs, had a prejudice against fish and would not eat it. At the present time there are two deep-sea fishing companies in Durban and five fishmongers, but we believe that little or nothing is done in the way of salting or drying fish. The Directory of Maritzburg does not mention a single fishmonger. Yet that salted and dried fish does find its way into the Colony is proved by the Government returns of imports. Taking the last year for which the returns have been published we find that in 1898 Natal imported 358,427 lbs. of dried or salted fish. Of this the Cape supplied 91,000, Calcutta 88,000, the United Kingdom 78,000 and Bombay 73,000. It will be seen that of these four, three are places where leprosy is known to prevail and if the bacillus may be introduced in fish we have here an obvious possibility. It is not possible to ascertain, excepting by careful enquiry on the spot, to what classes or to which localities the imported fish is distributed. The greater part of it may possibly be eaten by the coolies now abundant in the Colony. The question which presses for an answer is as to whether any of it has been sent to the places where leprosy has originated.

DRIED FISH IN CAPE COLONY.

MR. THEAL, the learned historiographer of the Cape, writes concerning leprosy (vol. ii. of "Records," p. 87): "It is not once named in the early records, and it is only from tradition that it is known to have existed amongst the Hottentots before their intercourse with strangers." He expresses a belief that it existed amongst both Hottentots and Bantus, but offers no proof whatever.

He adds that "the number affected must have been very small." It is fair to ask of contagionists why, if leprosy be a contagious disease and it was present in the Hottentot kraals whilst no precautions were taken, it should not have become very common. In his "History of South Africa" (p. 335) Mr. Theal tells us that the East India Company discouraged fishing stations at all places excepting Table Bay and False Bay. In 1718, however, it granted permission to fish and to cure fish in Saldanha Bay on condition that one-fifth of the dried commodity was paid as a tax to the Government. Thus we have proof that drying fish was a recognised pursuit at the Cape at that period. Mr. Theal adds that a great quantity of fish was taken in Table Bay by the free Malays and was sold at a very low rate. "The slaves within fifty miles of Cape Town were largely fed upon this diet, which was used also almost daily by the European inhabitants, and sometimes a trader would take into the interior a waggon-load of dried or smoked snoek (a species of pike) which he would exchange for sheep at an enormous profit."

It is obvious that if the leprosy bacillus may be conveyed in dried fish, that we have here a possibility as to the spreading of the disease which would exactly fit with what has happened. A few persons here and a few there have been infected.

DUTCH HABITS OF DIET.—"We were kindly invited to partake of their 'morgen-maal' (morning meal), which had more the character of dinner than of breakfast. The Dutch have a similar meal about eight in the evening, and these are the only times they eat in the country, the first meal being about ten or eleven o'clock. A cup of coffee is generally taken early in the morning, and frequently another, or a cup of tea, at uncertain intervals in the course of the day. In the remoter places it is often taken without milk or sugar. It is common to offer this beverage to strangers rather than wine or strong drink. Some travellers find fault with the quantity of sheep-tail fat used in cooking by the Boers, but after our long journeying this formed no obstacle with us."—(From *Backhouse's Journal*, 1844.)

*

*

*

JAMES BACKHOUSE ON THE BOER CREED.—"This kind of doctrine we had often to preach in this country, where there was a disposition to doubt the claims of the coloured races to Christian fellowship; and such an ignorance of ecclesiastical history as to render proofs of a very decisive character necessary, to produce the conviction that white men were not from the earliest ages Christians and the chosen people of God."

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

CLINICAL MEMORIES.

BY SIR WM. T. GAIRDNER, K.C.B.

(Abstract of a Lecture delivered at the Polyclinic, Wednesday, May 30.)

SIR WILLIAM GAIRDNER'S lecture consisted of a number of highly interesting recollections of clinical facts, with comments arising out of them. It was illustrated by numerous drawings and specimens. The subject which he first discussed was

The Prognosis of Mitral Stenosis.

The gravity of this prognosis he considers is much overstated in many text-books. It is necessarily true that stenosis of the mitral orifice carries with it certain considerable and definite risks which are by no means to be disregarded; but Sir William controverted the frequently stated position that it has the worst outlook of all the forms of cardiac valvular disease and related some of the observations which had led him to this conclusion. Special attention to the subject was excited many years ago by the late Dr. Angus Macdonald's work on "Heart Disease in Pregnancy," in which mitral stenosis was defined as a complication of the gravest possible character. As it had happened to Sir William Gairdner to have seen several cases of mitral stenosis in women who had passed through repeated pregnancies without any particular discomfort or harm, he suggested to his friend, Dr. Middleton, that the subject was one suitable for investigation. Dr. Middleton therefore commenced a series of observations at the Glasgow Royal Infirmary, and watched the patients concerned over a long period of years.

The results obtained were recorded in the *Lancet* of the day, and they showed conclusively that the gravity of mitral stenosis as related to the occurrence of pregnancy had been much exaggerated. Sir William related several cases from his own experience which sustained this position. In some of these the patients had borne numerous children and had been subject to conditions of prolonged anxiety and mental strain, and yet had been entirely free from symptomatic evidences of cardiac disease during the period of active sexual life. Mitral stenosis in some of these instances had been discovered as it were accidentally, or in later life, whilst the patient's history afforded no event to indicate the date of its development. In some a presumption as to the duration of the lesion might be established by the fact that hæmoptysis had occurred on one or more occasions, but in others there was no such guidance, nor was there any history of rheumatism, and it might be possible that the mitral stenosis in a proportion of the cases was of congenital origin. On the basis of an experience of many years, gathered from cases which had been under observation for prolonged periods, Sir William Gairdner is convinced that mitral stenosis is in many instances a condition which causes the patient but little disturbance, even over a term of many years, and that whilst it necessarily introduces certain risks and dangers, its existence does not invariably demand the grave prognosis often attached to it.

The next subject discussed was

Dr. Austin Flint's Murmur.

When in 1865 the late Dr. Austin Flint announced that he had seen two cases, each having clinically the murmur described by Sir William Gairdner under the term auricular-systolic (A.S.), and often called pre-systolic, and that in each instance there had been found a perfectly normal mitral orifice but an incompetent aortic valve, Sir William's attitude was one of surprise and even of incredulity. Such a state of matters was quite opposed to his own experience, and it seemed to him almost inconceivable that aortic regurgitation could possibly produce a murmur similar to that believed to be distinctive of mitral stenosis. The explanation that with a large measure of regurgitation at the aortic orifice the left

ventricle always contained a sufficient quantity of blood to "float up" the mitral curtains to such a height that they constituted a virtual obstruction to the flow of blood from the auricle, did not find any confirmation in his own experience, nor in that of Dr. Geo. Balfour. In comparatively recent years he had met with two cases which had somewhat modified his view that the A.S. murmur could not be produced by the physical conditions which led to aortic regurgitation. The specimen from one of these cases he now exhibited. It showed a small aneurism just above the aortic valves, and this projected in such a direction as to make it conceivable that it might diminish the size of the mitral orifice and so lead to the murmur of mitral obstruction. The mitral valve itself was healthy, yet during life a rasping pre-systolic murmur was heard at the apex, and there was also a measure of pre-systolic thrill. These facts were in addition to the usual V.S. and V.D. murmurs of aortic disease.

On Leucoderma in Addison's Disease.

Under this heading the lecturer discussed the question whether in Addison's disease the pigmentation of the skin ever assumed the character and pattern met with in leucoderma. He referred to the case figured (plate xi.) in Addison's original work showing quite typical leucoderma, and to the opposite contention of Sir Samuel Wilks to the effect that the discoloration of the skin in Addison's disease is never of this character. In his own experience Sir William Gairdner had many years ago seen a patient who was manifestly dying, and in whom no organic disease could be discovered: the skin was in places deeply pigmented, with intervening white patches; he had expressed the opinion that the case was one of Addison's disease, and this opinion was sustained by the *post-mortem* examination. At the International Medical Congress in 1881 he had mentioned this case in the discussion on Dr. Greenhow's paper, and had asked for some experiences on this matter, but his appeal had met with no response. Yet he had since seen two or three cases with a similar combination of events, and he now showed two photographs and two coloured drawings of a woman at present a patient in the Glasgow Western Infirmary, whose skin exhibited more or less general bronzing and patches of dark pigmentation,

alternating with areas of leucoderma. This condition of the skin had developed within the course of the last nine months, and had coincided with a gradually increasing bodily weakness. There were evidences of phthisis pulmonalis, slight at first, but undergoing considerable increase under observation. The question of diagnosis was whether the case was or was not one of disease of the suprarenal capsules. Were the pigmentation uniform few would deny the propriety of such a diagnosis, and Sir William Gairdner was not ready to admit that the distribution of the pigment in dark patches with intervening leucodermic areas was sufficient to negative the conclusion that the case was really one of Addison's disease.

The Treatment of Small-pox.

Sir Wm. Gairdner, in connection with this subject, gave an account of the various attempts that have been made to abort the pustules of the disease with a view especially to prevent disfigurement of the face. He referred to the theory at one time in vogue that this result would be attained provided only air could be excluded, and to the practice adopted by Hughes Bennett of covering the face with masks constructed of a variety of materials. Sir William himself had at one time adopted collodion, and after cautious experiments on the limbs, had subjected the method to a crucial test by painting over one side of the face and leaving the other exposed, in a man obviously sickening with small-pox. The experiment was not without anxiety in reference to the effect upon the individual immediately concerned, but the actual result showed an eruption equally abundant and severe on the two sides, and was therefore quite sufficient to discourage further attempts in the same direction. There was, however, another aspect of the question which might be kept in mind and which was suggested by a case which he illustrated. The patient, who was the subject of psoriasis, became attacked by small-pox, the eruption of which arranged itself in groups upon the psoriasis patches so that it to some extent resembled the variety of the disease described by Marson as "corymbose." Similarly in other patients the eruption has been seen to develop specially on areas to which blisters had been applied at some previous date. Such experiences raised the question whether it

might not be possible, by applying some form of counter-irritation to the back or elsewhere, to "attract" the eruption to some part of the surface where its presence would not be attended by the disadvantages and disfigurement which it caused when it attacked the face. Sir Wm. Gairdner had never had the chance of putting this suggestion to the test of practice, but he would be much inclined to do so if the opportunity happened to come his way.

*A Case of Dermanyssus Avium.*¹

In 1879 a very experienced and capable practitioner wrote to Sir William concerning the case of a lady "who in visiting the poor has become infested with lice." The usual treatment, even though pursued with some degree of vigour, proved unavailing, and the patient and practitioner were alike in despair. An examination of a specimen forwarded to Sir William showed that the parasite was not a pediculus, but was the *Dermanyssus avium*. It turned out that the patient often nursed some of the members of her poultry yard, and in this way no doubt she became infested by the parasite.

An Early Case of Cerebro-Spinal Meningitis.

This was related with a view to illustrate some directions in which the art of diagnosis has become more definite and precise. The condition was only recognised at the *post-mortem* examination, and the patient during life had been seen by five or six physicians, none of whom had come anywhere near an accurate diagnosis excepting Dr. Alison, who had suggested the presence of "some effusion on the brain." Amongst other suggested explanations of the symptoms was one provided by a gynæcologist, who discovered the patient to be suffering from "an undeveloped womb."

In the course of the lecture a number of illustrations showing various other clinical and pathological conditions were exhibited, and were made the subject of brief comment.

¹ Illustrations of this parasite from the pencil of the late Mr. Tuffen West are exhibited in the gallery of the Museum.—(ED.)

ON THE IMPORTANCE OF EARLY DIAGNOSIS AND TREATMENT IN SURGICAL DISEASES OF THE ABDOMEN.

BY WM. ROSE, B.S., F.R.C.S.

(Abstract of a Lecture delivered at the Polyclinic, on Wednesday, June 6.)

THE starting point from which Mr. Rose developed his lecture was the proposition that under modern conditions surgical interference in many cases of abdominal disease saves lives which in an earlier day would have been lost. This, he contended, necessarily involved the responsibility of securing that surgical measures should be applied in such cases under the most favourable circumstances. Experience is practically uniform that the chances of success are enormously greater when operative proceedings are put in force in the early stages of the case. Consequently, it is all important that the various abdominal conditions susceptible to surgical treatment should be recognised promptly, and when recognised should be at once given the chance provided by the surgeon's art. These desirable ends, the lecturer pointed out, could only be attained by obtaining the recognition of their importance by the general practitioner. The cases in their earliest developments were necessarily in his hands, and if he failed to recognise the significance of the symptoms at the outset, the patient might soon pass into a condition in which successful surgery was difficult or impossible. Mr. Rose strongly urged the necessity of a thorough physical examination in every case showing evidence of abdominal disturbance. Only in this way, and by a careful consideration of all the facts, is it possible to avoid the grave error of regarding the early symptoms of organic disease as the results of mere functional digestive disturbances. The postponement of a thorough investigation until something manifestly serious occurs only too frequently means the loss of the hopeful prospect afforded by an early operation. To illustrate his argument Mr. Rose gave a brief account of the symptoms of a

number of abdominal conditions in which surgical treatment is often necessary, and showed how in each of these instances the chances of success are seriously prejudiced by delay. In perforation of the stomach wall by a gastric ulcer, delay means a more wide diffusion of the foreign material through the peritoneal cavity and the necessity for more prolonged measures for cleansing the cavity, with frequently the necessity for making a second opening above the pubes with a view to establish effective drainage. Similarly, in cases of rupture of the intestine, the claim is for prompt operation. The claim here, indeed, is even more urgent than in a case of perforation of the stomach wall, as the material entering the peritoneal cavity is more virulent, and there is therefore a greater probability of an early peritonitis.

The surgical treatment of appendicitis was discussed at length. For the acute or "fulminating" cases early operation was insisted on as an absolute necessity, and as exceedingly desirable even in the instances where with a less urgent inflammation there is a probability that the general peritoneum will be protected from infection by the formation of adhesions. In these there is the risk of the abscesses burrowing in various directions, of slight but continuous leakage into the peritoneal cavity, of septic thrombosis in the veins of the meso-appendix with resulting portal-vein pyæmia, or of a general toxæmia from absorption. And any of these conditions necessarily considerably diminishes the chance of surgical success. Even should the process become quiescent and the inflammatory products remain localised by adhesions, there is a possibility that, perchance at a distant date, the adhesions may yield under the influence of some accidental strain and a generalised peritonitis be the result. Similarly, Mr. Rose argued in favour of early operation in the various forms and situations of cancer of the stomach, and showed by statistics how relatively favourable is the prognosis in such cases when this measure is adopted. On the other hand it was pointed out that to postpone operation means the probability of lymphatic involvement and the reduction of the patient's strength, and the risk of such an extension of the tumour as to render its complete removal impossible.

In view of the importance of early surgical treatment, Mr. Rose advocated the practice of exploratory incision in cases where there

exists a reasonable suspicion of the existence of a tumour, whilst in more doubtful cases, where the diagnosis between functional and organic disease is quite uncertain, he advised that the facts be communicated to the patient, with whom the ultimate decision for or against an exploratory operation should be left.

The lecturer also dealt with a number of practical points by attention to which the recognition of organic disease in the abdomen and its localisation may be aided, and in conclusion again emphasised the importance of subjecting all cases to an early and thorough physical examination.

THE BOERS' METHOD OF PROCURING SERVANTS.—“At a subsequent period a conversation took place, between an acquaintance of ours and an emigrant Boer, on the manner in which persons of the latter class obtained Hottentots beyond the frontier to herd their cattle. The Boer said they went to the kraals of the bushmen and brought them away. Our acquaintance inquired how they managed if the bushmen were unwilling to become their servants; the Boer replied, ‘we give them a bullet!’” We take the above from *Backhouse's Journal* (1844). It proves amongst other things that the Boers were then taking Hottentots, who were fish-eaters, into the Natal territory.

* * *

BOERS AND SLAVERY.—“But to-day I caught the painful remark of an artless individual, that plenty of slaves were to be had at Natal—so many coloured women had lost their husbands in the wars! Here, I apprehend, was one great root of the emigration of the Dutch colonists.”—(James Backhouse, 1844.)

* * *

LIVINGSTONE'S EXPERIENCE OF LEPROSY (from “Life of David Livingstone.”) —“On reaching Sesheke, where Sekeletu was, Dr. Livingstone found matters in a bad way with the Makololo. Sekeletu was suffering from leprosy, and had withdrawn himself from the sight of his people. He was sitting in a covered waggon, which was enclosed in a high wall of reeds. His face was slightly disfigured by the thickening and discoloration of the skin where the leprosy had passed over it. He had a firm belief that he had been bewitched. . . . Under Livingstone's treatment he all but recovered.” This was in 1860 and in the vicinity of the Victoria Falls. In the *Journal* (vol. v.) of the *Geographical Society*, 1860, it is said simply of the same case: “Sekeletu was labouring under a skin disease, and many headmen had been executed for the alleged crime of having caused it by their witchcraft,” p. 128.

THE CLINICAL RELATIONS OF ARTHRITIS.

BY WILLIAM M. ORD, M.D., F.R.C.P.

*(Concluded from page 357).**(4) Traumatic Arthritis.*

THIS has to be considered under two heads, the acute and chronic. Our common experience shows that sharp injury to a joint will produce an attack of arthritis. Most commonly with appropriate treatment the arthritis may be subdued. Not, however, in all cases. Two unpleasant kinds of result may follow. The local damage may be too serious to be effectively repaired; but it is important to recognise the fact that comparatively small injuries of a joint and, in my experience, more particularly of a small joint, may lead to not merely a chronic arthritis in that joint, but to an extension of an arthritic process to other joints more or less in a symmetrical order. I have seen in several cases apparently small injuries of small joints, producing excessive pain but not much inflammation, lead to a process of multiple arthritis. A thumb joint or a knuckle joint of the index or middle finger for instance. Generally, an injury which is received by a joint flexed with the articular surface exposed to a sharp blow, is not followed by a local inflammation, but remains very tender and painful when apparently the acute inflammation has subsided. The original injury is probably a direct damage of the cartilage of the joint. In some of these cases, the joint originally hurt being still painful, the corresponding joint on the opposite side of the body takes on arthritis. Later on another joint near that which was originally injured takes on the process, to be imitated by the corresponding joint on the other side, until, at last, this sort of amœbæan process, steadily increasing, the hands, and often the feet, become crippled in a very painful way. This occurs chiefly in elderly and anæmic patients, more often females than males.

The effects of chronic injury of joints are much more abundant

and much more distressing. They are the affections which crowd our out-patient rooms, our infirmaries and our homes for incurables. They are the outcome of excessive work and strain in elderly and enfeebled persons. They affect people of all kinds who use their limbs with prolonged and excessive strain, with imperfect nutrition, and with a diminished power of resistance growing with years. For instance, we find them in the washerwoman. Her hands are crippled by arthritis, usually with much swelling and tenderness and distortion, acquired by the great use which she has to make of her hands and fingers in wringing the articles she is called upon to wash. The same woman, having to stand a great part of the day, doubtless calling on the legs for much more than natural exertion, will present similar deformities of the feet and knees. According to the nature and distribution of the movement and stress involved, nearly every trade and occupation leaves characteristic traces of chronic traumatism, and when we study the series of cases we can very well recognise the influence of occupation in determining a chronic traumatism of certain joints as compared with others. The local changes seen in these cases are very different from those of Heberden's disease. The joints are very greatly enlarged and very irregularly deformed; they generally contain a great deal of fluid and present grating or crepitus on passive movement. For the most part, the proximal joints of the fingers or toes are most swollen, the tissues between them are a good deal swollen, while the ends of the fingers show a tendency to wasting or atrophy. A chronic uni-articular form of arthritis, dependent upon overstrain of this kind and known as chronic hip disease, occurring in old people, belongs to this class of cases. It is mostly the combined result of an acute or severe chronic local injury and subsequent chronic arthritis in adults and old persons who have to sustain weights or have to make excessive use of their lower limbs in the course of their occupation.

In this form of disease there is usually an enormous increase in the circumference of the acetabulum, due to extension of the peri-arthritis. At the same time, the femoral portion of the joint is greatly wasted, and lies like an attenuated pestle in the over-large mortar of the acetabulum.

We must now turn to another field of causes of arthritis. Our

line of thought to-day is essentially clinical, and, much as I should like to put before you in logical series the conditions at work, I think it better to approach it, as I did originally myself, from the clinical and not the didactic point of view.

That an important relation exists between troubles in the sexual organs of women, and of less degree of men, and the occurrence of arthritic changes of various kinds in relation to the local affections, has presented itself strongly to my mind for years. I said a few words before on the fact that Heberden's nodes were observed almost entirely in women. As a result of long observation, I am satisfied that arthritis is frequently associated with uterine troubles, is determined by them, and varies with their degree and intensity. Apart from pregnancy, the occurrence of more or less severe arthritis with painful menstruation, has made me see that painful arthritis has arisen, become intensified or has diminished, and passed away during severe dysmenorrhœa. I have seen many women who have described themselves as free from arthritic pain for only a few days between the periods of menstruation. A patient of this kind suffers during menstruation the most severe pains in the pelvic organs, sometimes with diminished, sometimes with increased flow; at the same time the joints are racked with pain, many of them becoming red, swollen, and tender. During this time the patient is completely overcome and prostrated by the pain in the whole of the body. A week before the establishment of the catamenia, the pains in the joints have begun with a severity enough to disable the patient; for a week after the cessation of the catamenia, the joint pains and troubles continue with gradual diminution, and there is only left the one week of comparative ease, to which I have referred, in the four weeks. During this period of less discomfort, the inflamed joints become quiescent, the swelling goes down, and, at all events in the earlier stages of such troubles, no permanent deformity is observed. Wherever it is possible to alleviate the uterine pains, alleviation of the rest of the sufferings is attained, but the treatment of cases of this kind can only be successful when the removal of the uterine instigation can in more or less degree be secured. A further step is to note the existence of a very large number of cases in which uterine hyperæmia and excessive painless menstrual flow are attended at each period with severe arthritis. I will here quote

an illustrative case. A lady, aged 56, the mother of twelve children, consulted me on account of what she called "her gout." Her catamenia were excessive and prolonged without association of local pain. An examination by experienced gynaecologists established the fact that the uterus was considerably enlarged and engorged, and when I saw her she was, and had been for some time, under treatment for the purely local trouble. It was on the side of the joints that she asked for my help. She stated that before the prolonged and excessive menstruation she had sudden and great swelling of the joints of the hand, in the wrist, in the elbow, and in the knees. These joints certainly looked very much like gouty joints, being enlarged, swollen, rather glossy, red, and very tender. There was really very good ground, if one saw the joints alone, for regarding them as presenting gouty inflammation. At the end of every menstruation the joints quieted down and presented no deformity or tenderness whatever, but for some years no menstrual period occurred without the occurrence of the trouble in the joints. At length the climacteric approached, and a period was missed. With its non-appearance there was a non-appearance of the joint affection. Presently the menstrual periods became more and more infrequent, and no joint affection occurred, excepting in conjunction with their occasional recurrence. When the periods finally ceased "the gout" ceased also, but did in fact occur twice afterwards under circumstances of great mental trouble and distress. The patient has now reached a considerable age, and has forgotten that she has had trouble in her joints. From what I have said you will understand that in this aspect of arthritis two conditions may work; firstly, dysmenorrhœa; secondly, metrorrhagia, without pain; but in both cases the existence of extreme uterine congestion is included, and is, I believe, the main provoking cause.

A careful consideration of the whole phenomena and the collation of a very considerable number of cases, leads me to the belief that the joint troubles are the result of reflex trophic influence, the excessive uterine irritation being reflected from the spinal cord to the joints.

Before going further in my analysis, I would draw your attention to what appears to me to be a parallel sequence of morbid phenomena in the case of men. Sir Benjamin Brodie, Mr. Stanley, and

others have drawn attention to the occurrence of gouty inflammations of the joints with inflammations of the urethra and of the prostate. It is unnecessary to say that primary difficulty arises here as regards the nature of the urethral and prostatic affection. It is quite possible that in many of these cases there may be gonorrhœal infection, and, as a result, the entry into the system of microbes capable of setting up inflammation in the joints. For my part, I have seen some cases—and I am bound to say that they are not numerous—in which the possibility of an affection of this kind was either small or nil—cases where a man would awake in the night with severe prostatic trouble and would present marked arthritis in the morning, associated in some cases with orchitis. We all know that there is a large number of elderly men who, having persistent prostatic trouble, have attacks of orchitis when the prostate is particularly troublesome. Few of us, I think, would say that these cases are due to introduced microbes. The orchitis, to me, appears to be one form of reflex irritation, while the arthritis is another. I am bound, however, to acknowledge the difficulty attending the investigation of such cases where the attainment of the exact truth is naturally very uncertain, but I have records of cases where a urethral and prostatic affection of many years' standing is associated, in a causative way, with arthritis. I have at the moment a patient under my care who has an enormous arthritic change in his knees, some less trouble in the hips, and little in the rest of the body. When I first saw him, some years ago, he struggled into my room, passing one leg before the other with the greatest difficulty and with much pain. His legs may be said to have been Z-like. The legs were bent strongly forward below the knees, the thighs strongly backward above, and he had to hold his body in a very difficult balancing position, so that his whole progression was somewhat tortoise-like. His knees were enormously enlarged and the joints contained a considerable quantity of fluid. Very large foreign bodies were present in the joints, making by themselves a very great deformity. The bones were also a good deal displaced, the femur overlapping the tibia to a large extent. The thigh muscles were very much wasted, the extensors more than the flexors.

This patient had suffered for many years from stricture, which

had been skilfully treated, but left him obliged to use a catheter regularly in order to keep the urethra patent. He had been to many bath-places, but had got most benefit from Droitwich, where the hot brine, used in more than one way, seemed to afford him considerable relief. Under my advice he continued some of the Droitwich treatment in London, using such appliances as packs for the knees and douches to the back and also regular massage and passive movements of the limbs. However, although improving very considerably (in fact, at the moment he can walk fairly well and can enjoy rowing) it became evident that whenever any extra irritation in the urethra occurred the joints became rapidly inflamed and tender. He stated decidedly that whenever he used the catheter, usually about once a week, the joints were more painful and troublesome the day after ; and one day when he visited me he was in very great pain in the joints. On this occasion I found that under the advice of a friend, non-medical, he had been using the catheter daily for a week. His joints when he came to see me were then worse as regarded pain and inflammatory condition than I had ever seen them before. After a decided limitation of the use of the catheter, the arthritic conditions ceased rapidly.

The case here was, to my mind, dependent upon a condition of transmission of irritation arising in the prostate and its neighbourhood, carried thence in a reflex way to the joints. The probability of such transmission has occurred to me in many cases. Urethritis capable of setting up mischief in joints may be, as we know, gonorrhœal. A fair examination of cases indicated to me that we have here to take into account, besides cases of primary prostatic inflammation and of stricture, other irritations of the prostate.

Among my arthritic patients I have been led to see that great prolonged sexual excitement of the prostate gland and parts around it may be found to act as an excitant of arthritic processes.

Let me state a case :—A stalwart man of fine conformation loses his wife in her first confinement. He lives alone, I believe with chastity, for some time. Presently he appears with arthritis involving the knees, and so severe as to interfere with locomotion. He marries again and the arthritic conditions disappear. He becomes again a strong man, but after some time his sexual relations become complicated and unsatisfactory by reason of serious

pelvic disturbances in his wife, and, in plain words, he reverts to the condition of the celibate. His knees become enlarged and painful; his power of walking without pain is diminished, and he falls day by day into the condition of a man suffering from chronic arthritis of the hips and knees, both painful and disabling. The result is that a man of great bodily development falls into a condition of comparative uselessness in his lower limbs. Here, I believe, that prolonged and enforced abstinence from sexual relations has brought about permanent excitement of the prostate sufficient to wreck the patient's comfort and enjoyment of life.

To my mind we have here a picture of a powerful man, with apparently strong sexual instincts, suffering, in the first place, from the sudden cessation of sexual intercourse, inducing indirectly arthritis in the knees, relieved by a second marriage from marked arthritis, and then having excitement and arthritis induced by something like a recurrence of the first trouble.

The intestines appear occasionally to affect the joints in a similar way, though I am bound to say the analysis here is not incontestable, and it is to be noted that pulmonary affection of the joints is believed by some observers to occur.

There remain for further consideration certain dystrophic nerve influences to be observed in affections of the central nerve organs. In organic affection of the spinal cord we have often to recognise arthritis associated more or less with each. We have spoken of Charcot's disease of joints.

But it is unnecessary to remind you of the fact that joints are affected in other forms of disease of the spinal cord in a direct and not in a reflex way. In progressive muscular atrophy, for instance, where we have to add in our notes of the disease, dystrophies of joints as well as of muscles. If we trouble to take care to examine cases of progressive muscular atrophy, we rarely fail to find an association of affection of the bone and joints. These are apparently not of a reflex kind, but are surely the direct result of an affection of the spinal cord, producing dystrophy of joints and bones, which in many ways resemble those which we have been discussing as effects of reflex irritation. I have seen and have quoted many cases in which joint changes, otherwise not explained, seem to fall slowly into the march of the conditions of progressive muscular atrophy.

As far as time allows me, I must go on to a consideration of the great factor of arthritis—gout. As regards gout, we have to recognise in full that the typical affection is one of joints. In the joints we meet with two kinds of process, one a very acute and painful inflammatory process, the other, often consequent upon the first, of a chronic and destructive kind. I will not dwell upon the first, but the second presents for us a steady impairment of joints punctuated from time to time by acute attacks. The chronic form of gout is full of dystrophy, and, as you know, runs a very variable course. There occur thickenings of the joints and the extremities, bringing about deformity, pain, and much loss of muscular power in connection with the joints affected. Changes, which we have not as yet noted, occur in the joints in addition to what we have already observed. We have to recognise the important fact of the deposit in the cartilages and other parts around the joints of urates. There is a great deal to be considered and looked for in the matter of determination of what these deposits mean. I dare to say that we do not at present understand how they come about, but we know that the effects of these deposits on joints are not quite the same as in the arthritic condition that we have been considering. In well-defined cases we find the joints, say of the hands, gradually thickened, but in addition there is a marked tendency to invade the fibrous tissue in the interval between the joints, along the course of the shaft of the bone, and, as compared with Heberden's nodes, we have a great and painful increase of size in the metacarpo-phalangeal joints, and in the intervals between them and the distal joints. The limitation of trouble to joints is in many gouty cases not to be recognised. The fingers, as a whole, are obviously affected by the deposits belonging to this form of arthritis, so that in marked cases the hand loses all its natural form in such a way as to suggest the well-known comparison of a bunch of carrots or of bananas. The local conditions here are of a kind different from anything else that we have been discussing. There is a deposit in the cartilage and fibrous surroundings of a material which is most probably irritant, but of whose actual meaning I think we must confess ourselves to be still ignorant. I dare not be didactic about either the cause or the treatment of gout, but I have the strong belief that, while it has a systemic comprehension, the joint manifestations are dependent

upon much larger conditions than an excess of uric acid in the blood. I believe that when we get to a much wider view of this matter we may be able to do more in the way of helping gout than we can at present effect. In my opinion the uric acid is the sign and not the essence of the disease.

I pass on to two further notes—(1) That arthritis may be of tubercular origin; and (2) of syphilitic; and that in a large review of arthritis general defect of nutrition, however arising, has to be regarded as a great factor.

To sum up; putting aside the use of all terms save arthritis, we have always to bear in our minds its numerous conditions and associations. A swollen, painful, and distorted joint may belong to age, may follow acute rheumatism, may be observed in Raynaud's disease (here in interesting relation with Heberden's disease), may be observed as a result of traumatism, acute or chronic; may be found to be related with injuries of shafts of bones distant from the joints subsequently affected; may be the work of the nervous system in many ways, direct or reflex, of gout, tubercle, syphilis, and general defect of nutrition. If you agree with this survey, I trust that you will recognise the importance of considering the whole aspects of a patient and his case when troubles in joints occur and have to be investigated. We have the generic term "arthritis" as the term from which we start; we have to go deeper and find the specific name which we may in our minds apply to each particular form. Therein comes the necessity of a deep and wide observation of every case of arthritis.

BOER FEEDING OF CHILDREN.—"We passed some Dutch people in a wagon, having a sick child; they afterwards sent an Irishman, who accompanied them, to request me to return, the child being worse, and they were afraid it was dying. It had taken a severe cold, and had symptoms of croup. Like many others of the children of the Boors, it was excessively fat, having been greatly overfed. After administering some suitable medicine, and counselling the parents against the mistaken notion, that giving the children great quantities of food is for their advantage, I followed my party."—(*Backhouse's Journal*, 1844.)

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY DR. WILLIAM EWART.

III.—*A case of Alcoholic Heart.*

THE patient, an engraver, aged 41, of full habit, was sent up for hospital treatment by one of my professional friends, with a history of recent, though not present, "alcoholic" habits (to which it is expedient on this occasion to refer to as "ethylic") and cardiac symptoms of six months' duration. The special feature in the case was, besides the cardio-hepatic aspect with yellowish conjunctivæ and some red acne of the face, a remarkable condition of the legs, which were exceedingly hard and brawny as well as enlarged, so closely resembling elephantiasis as to have led my friend to suspect this possibility.

This indurative anasarca, which was got well by rest in bed, elevating the feet and diligently bandaging and rebandaging the legs with flannel, is typically cardiac; the patient has no albumen, and there is no element of renal œdema in the case. I need hardly dwell upon the well-known differences between *cardiac and renal œdema*,—the latter independent of gravitation but greatly influenced by pressure,—the former chiefly determined by gravitation as in this case, for the patient had been standing and walking about for a long time, not being completely prostrated, whilst the heart was dilating. Much of the dropsy of advanced heart disease is a mixed dropsy, partly cardiac and partly renal, and we cannot trace in it any pure type. But feel the dropsy of uncomplicated chronic nephritis; you will find it exceedingly soft and easily displaced by pressure. If you should collect some of the œdematous fluid and test it, you will find it thin and charged with urea and extractives;

and when the patient, in addition to losing large quantities of albumen for months, has been for a long time upon a non-nitrogenous or a milk diet, it will, instead of containing, like the cardiac dropsical fluid, an excess of fibrin, give absolutely no precipitate with the tests for albumen, showing a state of the blood highly unfit for nutrition and ill-suited to restore the vitality of damaged tissues such as those of the kidney in chronic Bright's disease. This circumstance is a strong argument in favour of a principle of treatment which I laid before the Royal Medico-Chirurgical Society last year, that of endeavouring to *feed* nephritic patients.

It is a peculiarity of the alcoholic heart, so well described by Graham Steell (*Med. Chron.*, 1893, vol. xviii, p. 1), that although dilated and hypertrophied it is not, as in Bright's disease, associated with degenerated kidneys, but with merely congested kidneys, such as those found in common heart disease. This dilatation, like most others, is the result of malnutrition and of overstrain, and in that respect it is analogous to the dilatations seen in chlorosis and in toxæmic conditions. But there is a special method in this disease,—viz., a systematic malnutrition and poisoning alternating with periods of stimulation; the result is a starvation and toxic degeneration of the muscular fibres combined with that hypertrophy which we know is brought about by any stimulus acting intermittently. These peculiarities separate the dilated and hypertrophied heart of alcoholism, both as regards prognosis and treatment, from the condition resulting from renal disease where the causes, viz., the heightened blood pressure and peripheral vascular constriction, are permanent and progressive. There need be in these hearts no deep-seated structural change, but merely functional failures and faults. Nevertheless, Aufrecht has described a chronic interstitial myocarditis as resulting from alcoholism, and doubtless there must be varieties in the anatomical condition in individual cases according to the individual degree of renal soundness.

In this patient I am led to hope that fibrosis has not taken place, because of his prompt and considerable improvement under treatment, which has consisted of moderate doses of digitalis and strychnine, resistance movements, and Nauheim baths. His special complication is apparently hepatic rather than renal. The enlarged liver, having responded less fully to the treatment than the heart,

is under suspicion of some further changes beyond those of mere chronic congestion secondary to cardiac disease; and I have explained to him that if he is anxious to permanently re-establish his health, much time and the greatest care as regards diet will be needed over and above total abstention from alcohol. In the more favourable cases of this kind the disease can be to a great extent recovered from if the patient will consent to absolutely avoid any further toxic influence.

IV.—*A Case of Chorea and its Treatment.*

This case calls for few comments. The boy, aged 15, has had no rheumatism, but a previous attack of chorea three years ago beginning three weeks after a fright. His present attack began on February 28, three weeks after the death of his mother. On March 4 he was unable to speak, and he became steadily worse, but did not take to his bed. When admitted on March 8 he presented the usual signs and symptoms of the affection in an aggravated form. The agitation was so great that the skin of the arms, and of the trunk, particularly at the back, was much reddened, with threatening excoriation. Speech and articulation were almost impossible. He was ordered the usual sedative treatment which I employ at this stage—ammonium bromide, hyoscyamus, syrup of red poppies, in addition to a purge; but this did not control the symptoms, and the next day (March 9) he was ordered 10 grains of chloral every three hours until quieted. The skin had become more red and rough over the prominent surfaces.

On March 10, the agitation continuing, my house physician, Dr. Le Fleming, suggested a trial of the massive doses of arsenic:—

| | | | | | |
|-----------|------------------|-----|-----|-----|-------|
| R̄ | Liq. arsenicalis | ... | ... | ... | ℥ xv. |
| | Hst. caryoph. | ... | ... | ... | ʒ i. |
| Ft. mist. | | | | | |

Sig.—Three doses only to be taken.

But this had no effect in checking the agitation, and owing to the cutaneous irritation, the temperature began to rise (on the 11th to 99·6, on the 12th to 99·4). On the 12th I prescribed:—

| | | | | |
|----------------|-----|-----|-----|----------|
| Pot. iod. | ... | ... | ... | gr. vi |
| Sod. salicyl. | ... | ... | ... | gr. viii |
| Hst. pot. cit. | ... | ... | ad. | ʒ i. |

Four times daily.

And the next day the salicylate was increased to gr. xv. On the 13th the left elbow had been rubbed sore, and a splint had to be applied. There had been throughout no rheumatic pain or swelling, and no distinct murmur, though the sounds were not absolutely clear. At this stage, remembering the favourable results which I had previously noted in milder cases of chorea, I called to aid the sedative effect of carbonic acid. The effect of the first inhalation of a few minutes' duration was to quiet the patient considerably, to give him great comfort, and to enable him to utter a few words fairly deliberately. Finding him so much pleased with the result, I ordered the inhalation to be given for fifteen minutes every two hours. From that time his progress was uninterrupted. On the 14th he was able to sit up in his bed, and slept well through the night for the first time, and on the 15th he was able to feed himself and to talk with much less difficulty. The inhalations were interrupted on the 17th, but resumed on the 19th.

On March 20th I entered upon the second part of my routine treatment—the gradual administration of increasing doses of arsenic ; and Fowler's solution was added to the mixture day by day until we reached a few days ago 16 minims of arsenic at each of his three doses. A fit of vomiting caused us to return to the dose of 15 minims, which is now to be reduced, as he is so much better ; and I am now prescribing the acid solution of arsenic with nitro-muriatic acid and gentian. The inhalations have been discontinued since April 6.

You perceive at the upper part of the chest the marks of blisters which I prescribed, as soon as the agitation had been sufficiently controlled by carbonic acid inhalations, as part of Caton's prophylactic treatment for endocarditis, which also includes the administration of iodide of potassium.

No murmur has developed, and, it is to be hoped that there will be no return of the choreic symptoms, which are now considerably relieved. Two other cases, one of which was also severe, are undergoing the same treatment with equal success.

BY DR. R. L. BOWLES.

Case of Hemiplegia in a Boy.

CASE I.—This, as you see at once, is a case of right hemiplegia in a boy of 11 years of age, a condition so unusual apart from acute disease as to demand our special care and attention. His family history is good and there is no record of rheumatic fever, hereditary syphilis, or tubercular disease to guide us in our diagnosis. His present illness became definitely apparent last Saturday week (May 5, 1900), when he was observed to speak thickly and to walk as if he were drunk. On the following day he was unable to use his right hand and he dragged his right leg. There has never been any loss of consciousness. On close enquiry it was found that for three or four weeks previously he could not clean boots properly, and a week before the definite onset his teacher noticed that he was nervous and could not write as usual. You observe that he looks quite healthy, that his complexion is clear, and that his chest, heart, and other organs are healthy. The only sign of disease is the right hemiplegia, which, as usual, involves the right side of the face, and there are a few slightly enlarged cervical glands. He has not had any night sweats, cough, or fever, and there are no symptoms of intracranial tumour.

It is, as I have said, unusual to meet with a case of definite hemiplegia like this in one so young and healthy looking: the pathological conditions which lead up to that disease in people of more mature age do not exist, and we know that in many cases of hemiplegia arising from thrombosis the onset of the attack may be gradual: these two fundamental principles help us to arrive at the probable diagnosis of “cerebral thrombosis of unknown origin.”

For treatment, gray powder is being administered, and we may suggest, to relieve secondary irritations, that a blister to the nape of the neck may be useful.

Case of Doubtful Aortic Regurgitation.

CASE II.—This man says he is 50 years of age and that he gets his living as a singer in public houses. His personal history is—rheumatic fever in 1874 and in 1884, bronchitis frequently, and

syphilis thirty years ago, and that he has been a heavy drinker. He has pains in the precordial region which he says shoot up both sides of the neck and down both arms. There is palpitation and shortness of breath on exertion, and he has often fainted. His feet often swell. The sputum has contained blood and he has frequently vomited blood, sometimes in large quantities, but for the last twelve months this symptom has been entirely absent, and, lastly, he is very nervous. He has been in several hospitals, and says that "aortic regurgitation" was always written on his card. On examination his pulse certainly does give one the idea of aortic regurgitation, but there is, as you see, no cervical arterial pulsation, and, on auscultating the heart, no murmur of any kind can be heard; even after causing him to walk briskly about the room, we only find a slight blowing sound with the aortic systole, a sound not unusual in nervous subjects and not necessarily significant of cardiac disease.

Here, gentlemen, we have a history of a life tending to the development of degrading pathological changes of many kinds, and a very definite assertion backed, so the patient says, by the opinion of physicians in many hospitals that he is suffering from aortic regurgitations, that he has had definite symptoms of angina pectoris and of anasarca.

Now, on examination, neither I nor you, who have also examined him, can find at the present time any trace of aortic regurgitant murmur or other definite sign of heart disease, nor any trace of anasarca. In my experience I have never known a patient who has once had aortic regurgitation lose the sound of it, although I have cases of that disease still under my care which have been under observation for twenty-five, twelve, eleven, and ten years respectively. All of these are still alive, and all but one, who has large cavities in his lungs, enjoy good health and suffer from but few discomforts so long as they are prudent and do not hurry or face hills or stairs without some reflection and care. In the case of twenty-five years' standing the patient, now about 75, is quite well and happy, and his improvement dates from the time of his giving up, twenty years ago, the anxious position of master in one of our public schools. A quiet nervous system, careful living, and judicious medical help do much to improve many forms of heart disease.

Is this man a malingerer and lover of hospital life, or "a neurotic" who believes in his illness and unintentionally puzzles us, or could his doctors all have been mistaken, or may regurgitant aortic murmurs become intermittent?

Double Cardiac Murmurs in a Boy.

CASE III.—This boy, 16 years of age, believed himself to be perfectly well and strong until he was examined by a doctor in reference to a post on the railway, when, to his great surprise, he was rejected for disease of the heart. His family history is good, and, although when young he suffered from whooping cough and small-pox, he had no knowledge of their having left any traces of mischief behind. He has frequented a gymnasium and played cricket and football and other games in the usual way, but admits that he thinks he was shorter of breath and had more palpitations than other boys. On examination he is found to have well marked aortic and mitral systolic murmurs. They are quite synchronous, and the question comes as to whether they arise from valvular faults at each orifice, *i.e.*, from roughness or narrowing of the aortic orifice and regurgitant leakage through the mitral orifice, or whether both apparently separate sounds arise from a defect of one orifice and the single murmur being communicated to the other.

This is not an uncommon puzzle to the auscultator, but we are guided somewhat in this case by the fact that the sound diminishes in intensity as we follow it from the aortic area towards the mitral, and then increases as we approach the mitral area. Our opinion is, therefore, that in this case both sets of valves are involved. The heart's impulse is felt over a large area and is somewhat heaving in character.

Is the condition congenital or acquired? I confess I do not know; there is, as you see, no history of any acute heart attack, and one of you, to whom we must all listen with attention, asks: "May not both sounds be altogether functional?"

The intensity of the murmurs and the evidence of the increased size of the organ is, I think, opposed to that view.

Can anything be done for him?

The tendency to compensation in the young is so great that the

avoidance of sudden and violent effort and persistent prudence in living may do much for him in the future.

Senile Tuberculosis with Emphysema.

CASE IV.—A labourer, 66 years of age, but looking much older. He says he was healthy until six years ago, when he began to get thinner and to cough and expectorate. He has gradually become worse, and the expectoration is now yellowish and often mingled with blood. His appetite is poor, and he has palpitation and shortness of breath on exertion; he has, too, difficulty in passing water, which is thick and slimy. On examination his chest is small above and barrel-shaped below. There is dulness at the right apex, but the rest of the chest is hyper-resonant and the area of the heart's dulness is diminished. At the left apex, fine, dry ronchi can be heard, at the right apex harsh breathing ronchi and moist sounds. Over the rest of the lungs harsh breathing with prolonged expiration. Our diagnosis must be, I think, tubercular disease of the lungs with emphysema and cystitis.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. JONATHAN HUTCHINSON.

(Continued from p. 310.)

AMONGST the cases which attended at my Clinic on Thursday, June 21, were the following:—

XV.—*Chancre of the Meatus.*

The subject of this case was a lad of 20. He was covered by a blotchy eruption and had hard glands in both groins. The chancre was peculiar; it surrounded the meatus and involved the adjacent part of the glans in a thick ring of induration, the surface of which was ulcerated and as large as a shilling. In the middle of this ulcer, but not to be distinguished by the eye, was the urethral

orifice. The adjacent part of the frænum was involved. I remarked that had the patient been an old man, and other symptoms absent, there would have been nothing to exclude the diagnosis of epithelial cancer. The granulated surface of the ulceration and the great extent of the surrounding induration were strongly suggestive of that diagnosis. The lad's age, however, and the concomitant symptoms made it easy to avoid error.

In this case the boy alleged firmly that he had never been exposed to risk, and with such apparent truthfulness, that more than one present expressed their willingness to accept his statement. In support of their credulity, I remarked that the meatus is precisely the part most likely to incur accidental infection at a water closet.

XVI.—*Molluscum Contagiosum following a Scald.*

The subject of this case (one for which we were indebted to Mr. Hichens) was a child of a year old, who about three months ago had been scalded with almost boiling coffee on the right arm. The scald was sufficiently severe to require dressings of oil, &c., for a fortnight, but it had not left any scar. In the bend of the elbow, near the middle of the scald, there had appeared a large group of little molluscous buttons. There could be no doubt about the diagnosis, for some of the buttons were quite characteristic. The majority, however, were very small, not bigger than pins' heads, and as all were somewhat inflamed, and many confluent, they might not have been recognised at first glance. The child had none elsewhere, and its mother knew of no other children who had them. I remarked that we had long been aware that molluscum contagiosum was apt to occur in frequenters of the Turkish bath, and had been at a loss to explain the connection, since no contagion could ever be traced. The present case, the first in which I had ever known it attributed to a scald, suggested that possibly the heat-irritation might itself be the excitant which induced these curious growths. In the Turkish bath cases, as in the present instance, the eruption was seldom generalised but occurred as a single group of spots. There could be no doubt that when once set up the eruption was contagious, but we must not hastily assume from this fact that it could not possibly be originated excepting by

contagion. Even admitting its association with a living parasite, there remained the possibility that latent germs might be present in the hair follicles which awaited an extraordinary stimulus to rouse them into action. Our knowledge of these matters was not, I urged, sufficiently full to justify dogmatic conclusions respecting what is possible. The facts before us certainly suggested the hypothesis that the application of extraordinary heat in fluid form might initiate molluscum contagiosum.

XVII.—*Symmetrically Undescended Testes.*

In this case a boy of 14 presented a quite empty “purse,” and symmetrically placed swellings in both groins. These swellings, which were conspicuous in the erect posture, disappeared entirely when he was placed on the couch. They received an impulse on coughing but it was not expansile.

I drew attention in this case to the rarity of the bilateral symmetry which was such a conspicuous feature. The testes on both sides appeared to occupy the inguinal canal and to be capable of receding very easily into the abdomen. Although quite visible, yet they probably never escaped the external ring. I expressed doubts as to whether it would be advisable to attempt any operation for the better placement of the testicles. The boy did not suffer much inconvenience, and perhaps it might be better to let things alone, and be content to advise him to avoid all vigorous exertion. Had the affection been one-sided only, removal of the gland might be the most radical measure and at the same time the best, but the fact that it was double must modify our recommendation in this respect. No truss or other mechanical appliance could be of any use.

XVIII.—*Generalised Vaccinia Eruption after Vaccination.*

This was a very important case. The infant, a girl of three months, had been vaccinated a fortnight ago. The pocks, four in number, had taken well and were now involved in a common area of inflammatory swelling. This did not, however, extend upon the arm, and though somewhat excessive presented no unusual features. The pocks were purulent and were forming scabs. The eruption which now covered the whole surface had commenced, we were told,

on the eighth day, and had been first noticed on the forehead. It had rapidly shown itself on other parts, and now covered the trunk and limbs, but had faded from the face. The character of the eruption was somewhat indefinite. In the main it was a patchy erythema, but in many places it looked like an ill-developed urticaria. It was nowhere vesicular or pustular. About the hips it was almost papular and of a dusky tint, so that, had the child been syphilitic, it would have been regarded as characteristic. There was not, however, the slightest reason to suspect syphilis, for the child was the youngest of four and had been in perfect health up to the time of vaccination. There was no material fever but the child seemed to suffer somewhat from the irritation of the eruption. The latter was especially abundant on the upper extremities, hips and thighs, but occurred more or less over the whole surface.

In discussing the diagnosis I drew attention to the fact that there had been no continuity of the dermatitis with that which surrounded the pocks themselves. The eruption had developed symmetrically on distant parts, and was clearly due to a blood cause. No doubt it was a true Vaccinia, that is, an exanthem due to vaccination in the same way that the eruption of small-pox follows variolation. Sometimes these vaccinia eruptions exactly resemble variola, but they may vary considerably. The date at which the eruption had appeared fitted with this diagnosis. Could we predict that it would like an exanthem quickly fade away? I expressed a fear that we could not. It was very extensive and severe, and parts of it looked much like urticaria. Its presence probably revealed a certain degree of urticarious susceptibility in the child, and in some such cases puriginous irritability of the skin was apt to supervene and to last for a long time. It would be of great interest to watch the sequel of the case.

We were indebted to Dr. Sequeira for this case.

XIX.—*A Case of Eczema Psoriasis.*

The subject of this case was a man of 26, who for many years had had patches of "eczema" on his legs. The patches were of irregular form, some of them ill-defined, others abruptly so. They showed rough, reddened, and slightly scaly surfaces. There were

none above the knees, and the man asserted that he had none elsewhere. There were none on the fronts of the knees. In spite of the man's assurance that he had no patches on other parts, we insisted that he should undress. This done we found his assertion confirmed as regards the skin of his thighs, trunk, and upper arms. It was everywhere perfectly clear. Upon his elbows, however, on both sides he had most characteristic patches of psoriasis, and near to them on the backs of the forearms were others less definite and looking more like dry eczema.

I remarked that the case must certainly be regarded as one of psoriasis, but it was one of a peculiar type. It was one in which the phenomena of nummular eczema and psoriasis were mixed. Such cases were common, and justified a quite definite prognosis. The eruption would be very difficult of cure, and would relapse in spite of treatment. In this feature it was psoriasis. It would never, however, produce the characteristic eruption of psoriasis on the trunk, and might very probably affect parts, such as the flexures, the genitals, the ears, which common psoriasis usually avoids. It might, as in this instance, be very abundant on the legs and almost confined to them, a feature scarcely ever seen in typical psoriasis. Still the eruption must be regarded as being essentially psoriasis, and as due to some unknown peculiarity in the skin quite compatible with good health but certain to last for life. In hereditary transmission these eruptions, the common type of psoriasis and the common types of eczema were transmutable.

DISEASES OF THE THROAT.

BY MR. RICHARD LAKE.

Paralysis of Right Recurrent Laryngeal with Paresis of Palate, Trapezius, and Sterno-Mastoids.

THE patient, a man of 36, sent by Dr. Purdy, had suffered some years previously from Jacksonian epilepsy, but gave no specific history. He partially lost his voice two years ago, and had a

cough resembling that of whooping-cough. His right vocal cord is fixed, his right sterno-mastoid and trapezius distinctly atrophied and softened, his pupils contracted and immobile, reacting neither to light nor accommodation. There is paresis of the right half of the palate, some vasomotor disturbance with loss of sensation of the right half of the face. Specific treatment has been tried with negative results. A similar combination of paresis was recorded by Sir Morell Mackenzie in 1861. The causation is quite obscure. Dr. Aldren Turner, who has examined him, is inclined to regard it as of tabetic origin, or it may be due to some extensive lesion of the floor of the fourth ventricle, or possibly a growth at the base of the skull pressing upon the cranial nerves as they emerge from the medulla and pons. Injections of strychnine have afforded him some relief. The spasmodic cough of which he speaks may have been of the character of laryngeal crises, and fits in with the tabetic theory of causation.

A point of much interest was the *apparent* movement of the fixed cord. In order to demonstrate this a mirror with a line or spot marked on its surface must be used, and by keeping the mark at the edge of the cord during phonation, it becomes clear that the cord itself does not move, but that the cartilages of Wrisberg and Santorini upon the paralysed side do approach the median line. This is brought about by the oblique bundle of fibres of the arytenoidæus muscle, which arising at the base of the *left* arytenoid cartilage pass below the two smaller cartilages and on into the *right* aryepiglottic fold, and are, of course, supplied by the left recurrent nerve.

Stricture of the Œsophagus, probably Malignant.

The patient, a man of 63, sent by Dr. F. Spicer, has complained of difficulty in swallowing for three months past. This has been somewhat relieved by the passage of bougies, but a little bleeding has followed their use on one or two occasions.

He complains of little pain, but has been losing weight, and an enlarged and hardened gland can be felt deep in the neck, behind the trachea, at about the level of the cricoid cartilage on the left side. His dysphagia is not constant, but at times, as he expresses

it, "the food seems to stick, and then it all comes up," which points to some pouching of the œsophagus having taken place.

An attempt to pass a bougie meets with firm resistance about seven inches from the teeth. The patient admits syphilis, but there is no history of ulceration.

Pachyderma Laryngis in a Tubercular Larynx.

A young man of 23 has complained of cough for thirteen weeks past, but no pain or difficulty of swallowing. His voice is considerably altered, being muffled in character.

Upon the posterior part of the right vocal cord can be seen two small nodular patches or "pimples" of epithelial thickening. These are nearly of the nature of friction "corns" at the tip of the vocal process of the arytenoid, as this is the precise region of the cord which strikes inevitably and most forcibly against the opposite band in coughing, the third of the bands behind it being kept apart by the inter-arytenoid folds or mass, and the two-thirds in front being saved from contact by their elasticity. In chronic cough this particular point in the cord is struck incessantly against its fellow of the opposite side until a callus-like piling up of epithelium takes place.

In other cases the reaction takes a more acute course, congestion develops, followed by an ulcer which may extend a considerable distance along the edge of the vocal band, forming the "terraced" ulcer of Stoerk.

These pachydermatous enlargements upon the cord may take the form of a convex knob upon one band and a cup-like depression to fit it upon the other, and a specimen presented by Mr. Lake may now be seen in the museum of the College of Surgeons, in which they are of the size of the tip of the little finger.

REVIEWS AND NOTICES OF BOOKS.

- I.—THE CAPE OF GOOD HOPE LEPROSY COMMISSION, 1894. *Minutes of Evidence*, vol. i., a Blue Book, pp. 601. Cape Town.
- II.—THE SAME. INTERIM REPORT OF COMMISSIONERS. *Minutes of Proceedings and Appendix*, vol. ii.
- III.—THE SAME. *Abstract of Replies to Interrogations; Correspondence; Acts relating to Leprosy, &c.*, vol. iii.
- IV.—THE SAME. FINAL REPORT OF COMMISSION. *Minutes of Proceedings and Appendix*, vol. iv.

(Continued from page 397).

WE continue from last month our somewhat detailed extracts from these very important Reports. With but little exception we leave, without comment, the statements of witnesses to convey their own impression.

HOME-LONGINGS OF THE PATIENTS ON ROBBEN ISLAND.

The Commissioners write on this subject:—

“The chief and universal complaint of the male lepers is of their *separation from their friends and families*.” “They wish to go home, there is nothing on the island that pleases them,” and “they consider themselves the unhappiest people in the world.”

The following expressions of patients are quoted:

“It is simply killing me to stop here.”

“I am exceedingly anxious to go home from the island.”

“I wish to leave the island and go to my home; that is my great complaint; our hearts long very much to go home; my only longing is to go home.”

“I do not care about food; my greatest longing is to get away from the island.”

“I only want to go home; my heart is very sore, as I have a wife and children, and I want to see them.” (Page 25, vol. ii.)

From Dr. Kohler’s evidence before the Commission we take the following (after referring to the food, lodging, &c.):—

“But all these complaints are secondary, and the most commodious institution would not come into consideration against the one great and touching complaint which they have, viz., home-sickness. They do not care in the least for checking their disease, but home-sickness takes all their rest away, and only through that they feel very unhappy. When I told them that I was sent by the President of

the Free State they became exceedingly cheerful, and asked me if I came to fetch them. As hope makes everything bearable I gave them a little hope for the future. Some amongst them pleaded, with tears in their eyes, their desire to go home. If they could only live in the Free State, they said, then they could be content, even if they were segregated; they could see and speak to their relations. The warder who is always amongst them told me that they think about that day and night, and he felt sure that if anybody came to fetch them some of them would die for joy." (Page 24, vol. ii.)

Dr. Jane Waterston, an official inspector of Robben Island, was asked whether she found the lepers discontented about anything, and answered :—

"They seem to object principally to being away from home." She could speak Kafir, and added : "I have talked to the Kafirs who cannot understand English, and they tell me that their only complaint is that they are away from their homes and children. That seems to be their only grievance. . . . Their one desire is to get away from the island. . . . They simply complain of being so far away from home."

Mr. David Mudie, another official visitor of the island, in answer to the question, "Have the lepers complained at all about the climate?" informed the Commission :—

"No; their great complaint is that they are separated from their friends. We often find them bursting into tears, especially those who have children, husbands, or wives. That is the only thing practically that they complain about; the other complaints are comparatively of a trifling nature."

Mr. W. E. Moore, another visitor, in reply to a similar question, replied :—

"Their one complaint is that they want to go home. They complain that they are torn away from their families and friends. They say that they have committed no crime, and they desire to be restored to their families."

Further on, Mr. Moore added :—

"I feel rather strongly upon the matter, because these people have committed no crime, and they are virtually imprisoned for life. The greatest criminal can look forward to his freedom some day, but these people are placed on the island to die. As they are put there for the public good the public should be prepared to see that their comforts are amply studied and not allow them to feel that they are entirely isolated from the world; and that is at present really the effect upon them. The female lepers are kept within a compound, which is, of course, a great hardship."

Mr. Rutherford, another official visitor, had it suggested to him by one of the Commission that as his time in his visit to the island was limited he could not speak to many of the patients, he replied :—

"No; they speak to me before I speak to them, and always on the same point—about the separation from their friends and relatives."

The Chairman of the Commission inquired whether more could not be done in the way of providing amusement for the patients. He was replied to by Dr. Todd, one of the medical officers :—

“Concerts have been a failure; they have not cared to attend. Games have been sent over by friends, but they are soon broken, and last a very short time. The men do not take much interest in them.

“(3,686). Do you attribute that to the social condition of the men, or does the disease render them apathetic?—Their great desire is to go home, and they do not seem to care for anything.”

The following extracts are from evidence given by the patients themselves :—

Andries Rudolph was examined and asked—

“(3,212). Have you any complaints to make?—My only complaint is that long to go home.

“(3,237). How do you amuse yourselves?—We wander about the island, play a little and sleep.”

Jeary Galatze was asked the often-repeated question, and gave the usual answer.

“(3,254). Have you any complaints to make?—Only that I want to go home.”

Albert Truslar, Caspar Kean, and several others were questioned, and all returned the same pathetic answer. D. J. Du Plessis added: “I was much healthier at home at the Paarl. I consider that I was brought here in a scandalous manner. The doctor came and said he wanted to see me; and afterwards I got a letter from the magistrate saying I must be removed to Robben Island. . . . I know a man at Klapmuts who suffers from leprosy, and another at the Paarl, and it is not just that some persons should be singled out and sent here while others suffering from the same disease should remain at home.”

Mrs. S. Arendre was examined and asked—

“(3,333). Do you represent the female patients?—Yes; I am a Malay, and have ten children. I was forced to leave them.

“(3,336). Have you any complaints to make?—I do not want to complain about the food or anything else; I only want to get back to my children. . . . My last baby was only three months old when they took me away from home. There is no one to look after the children.

“(3,347). Would you prefer being in an asylum on the mainland?—Yes; it is very hard for me. I do not know what has become of my children. They have no mother to look after them.”

A paying patient was asked whether anything could be done to add to his comfort, replied :—

“I only want to go home.” Another patient sent as a deputation from one of the wards was asked if he had anything to complain of, and replied: “Only that I wish to leave the island and go to my home; that is my great complaint. Our hearts long very much to go home.

“Are you a married man?—No, but I have brothers and sisters.

"Would it not be a very bad thing if you left here and carried the disease to them?—I stayed among them when I had the disease two or three years, and I do not think it is contagious. They are quite as healthy as when I left them.

"Do you get plenty to eat?—Yes, but I do not care about that; my greatest longing is to get away from the island."

Jumbo, a Hottentot, a delegate from No. 4 Ward, deposed :—

"I want to get home very much, as I have a wife and family.

"(3,190). Do you not think it is very kind of the Government to look after you and give you a comfortable dwelling and good food, when, if you were at large, you might spread the disease?—I do not care about the food, although there is nothing to complain of. I want to see my wife and children; she does not get the food."

Caspar Lindeboorn, another patient said :—

"I do not want to make any complaint about the food. I only want to go home. My heart is very sore, as I have a wife and children, and want to see them.

"(3,204). Are your children very young?—The youngest is 4 years old and the oldest 14; they cannot work for themselves."

LOCALITIES AFFECTED.

The Rev. R. S. Nichols said :—

"(8,072). SALDANAH BAY is the worst place of all for lepers.

"(8,064). The Pieterse family was a large one, and four of the daughters decidedly died of leprosy. There are lepers at Stumpnose Bay and Paternoster.

"(8,066). What were the conditions of life of the Pieterse family? They lived in Britannia Bay just outside St. Helena Bay, in pondocks, and they ate a great deal of salt fish, harders, bakkems, and mocks.

"(8,067). Did they salt and cure the fish and then eat it? Yes.

"(8,068). Was that their principal article of diet? Yes, they did not get much meat and no vegetables. Mr. Jacobus Schicherling has a large business and fishery there."

Dr. Moore also gave evidence that there were lepers at Saldanha Bay.

Mr. Fuller said that there was a little colony at EAST LONDON, and that a Dr. Paley kept them under observation.

Dr. Smuts, for forty-eight years a practitioner at STELLENBOSCH was asked :—

"(5,872). Do your people use much salt fish? They do use it but not a great deal.

"(5,873). Do, you think the disease is spread equally all over the district, or have you observed more cases in certain parts? No, I have not."

Asked as to how the Leper Act worked, Dr. Smuts said :—"I am against sending these unfortunate people to Robben Island, and always take the most lenient view I can and give them the benefit."

"(5,890). Do you approve of the present system of segregation on Robben Island? No; I think it is very wrong and it is a hardship. It is not proved that the disease is contagious, and supposing it is so, it is in such a slight degree as not to justify such extreme measures and banishment of these people, many of whom would prefer death to being sent to Robben Island."

Dr. Smuts further deposed that during the last three years he had had thirty cases of leprosy under care; none of them in whites. He thought the disease hereditary, and though he had never seen an infant leprotic at birth, he had, he thought, seen the disease in an infant only a few months old, the grandchild of a leper.

Dr. Henry Clarke, district surgeon at Simonstown, said that he had seen cases at CLAN WILLIAM. They were mixed Hottentots by race, and were partially segregated near the Oliphants river. He thought there were about twenty there. Subsequently he went to Calvinia, where there were very few cases; not more than two, and living at large. After that he resided at Genge where he saw two cases; and after that at Simonstown where he met with thirteen. He believed it to be increasing in SIMONSTOWN and KALK BAY. He believed that leprosy had been endemic in Kalk Bay for years.

"(8,343). As regards the hygienic surroundings of the patients you saw, take the Kalk Bay group; what was the condition of life as regards the dwellings? With the exception of ——— they were all fishermen, as far as I remember, living in huts and crowded together.

"(8,344). As regards their diet, what did they live on mainly? I do not know whether they lived exclusively on fish.

"(8,345). Did they eat a good deal of salt fish? I think they eat fresh fish.

"(8,347). What race were they? Mixed race, a few were Malays.

"(8,349). Were the Manilla boys much affected? I think most of the patients were ordinary Cape natives."

Dr. George Eyre was asked what was the feeling as regards lepers in BLOEMFONTEIN, and replied:—

"I think the Bloemfontein people would much rather the lepers were sent to Robben Island, so as to relieve the country of them.

"(6,155). Do you know of any white lepers from the Free State? Yes; I have examined some of them personally."

Dr. Savage (referred to by Dr. Eyre) was sent by the Government into BASUTOLAND, and reported that there were 200 lepers, more or less.

The Rev. W. Watkins (chaplain) referring to the long distances which some of the patients had been brought, said, "There are a

good many patients from the FREE STATE and some from Uitenhage, Port Elizabeth and King Williamstown."

Dr. Kohler (visitor from the FREE STATE) said that on the occasion of his visits he did not remember to have seen any white patients from the Free State. He knew privately that there were some at liberty "who would never be segregated," vol. i., p. 445.

The Rev. Canon Baker deposed:—

"I have seen individual cases in Kalk Bay. I remember the case of a leper woman who lived in the bush at Kalk Bay, *near the fishery*, through whom it was thought the disease was communicated to a certain family in consequence of one of the children being in the habit of playing near her hut."

What more likely than that the woman gave the child some of her fish-food, or that, as the "certain family" lived near the fishery, that they also, as well as the old woman, ate fish largely. Kalk Bay has a Malay fish-curing establishment. The Malays engaged in it have leprosy. Canon Baker adds, "I frequently saw the Malay mason Fakeer's wife, who was a leper, but died of fish poisoning."

In spite of the obvious possibility that all might in this locality obtain the disease from a dietetic cause common to all, Canon Baker gravely records as proof of contagion "a well-known case," in which the son of a school teacher "believed he caught the disease by digging with a spade which his servant had been using."

INEFFICIENCY OF THE SEGREGATION ON ROBBEN ISLAND.

Miss Lucilla Spring, of the Sufferers Aid Society, stated that she had often visited Robben Island.

"(7,749). Have you noticed other visitors there? Yes; sometimes a great many.

"(7,750). Did some of the visitors share food with the lepers at times? They used to bring things over and sit together and eat.

"(7,751). Did they not seem afraid at all of the disease? No; I used almost to wish that they were afraid.

"(7,752). Did young children sometimes come over? Yes.

"(7,754). Were the visitors allowed to go into the sleeping rooms and through the whole building to see their friends? Yes; they sat mostly in the sleeping rooms.

"Was there no receiving room for visitors? No."

Mrs. Pomeray, a nurse, was asked:—

"(7,864). How many on an average come on visiting days to your ward? Not more than half a dozen on the average. Some days there are as many as twenty and on some days only two.

"(7,865). Are they allowed to stroll about any part of the island with the male lepers? Yes.

"(7,866). There is freedom as regards that? Yes, just so.

"(7,867). Do visitors sometimes bring presents of sweets, cake, fruit, and so on? Yes.

"(7,868). Do they sit down and eat together? They do not sit at the table with the lepers, but I daresay they eat by the bedside.

"(7,869). Have you ever seen them using the same plate or spoon? I have seen them taking tea and coffee together, and they must use the same cups because there are no others.

"(7,870). As regards the female lepers, have you seen the visitors kissing them without any fear? Yes.

"(7,871). Is the visiting under the same conditions in the female as in the male wards? It used to be when I was there.

"(7,872). Were the women allowed outside the fence? I used to take them out every afternoon for exercise."

Antonio Periero, the boatman for the island, was asked, "Do you keep a shop in the leper section? Yes."

"(8,642). Who takes charge of it? My wife.

"(8,643). Are there any regulations so as to avoid risk of contagion? No, none whatever."

Miss S. Deager, a visitor from the Cape General Mission, was asked:—

"Do you think the female patients should have more liberty? I have often thought it must be very hard to be locked up all day, except when they go out for a little walk.

"(8,687). You are aware that visitors go over to see their friends? Yes.

"(8,688). Do they kiss each other, shake hands, and so on? Yes. I was very much struck with one woman who was very bad; her child was brought to her and she hugged and kissed it all the time.

"(8,689). Have you often seen kissing going on between patients and their friends? Yes."

In reference to the removal of the non-leprous children now with their mothers in the leper wards, Dr. Impey (superintendent) told the Commission:—

"There is one child who has paralysis . . . it lies in bed all day, and the mother, who is a self-cured case, is devoted to it. I am certain that if you took that child away the mother would become like a demon, and you could not manage her, and if all the eleven children were taken away there would be eleven demons in the wards.

"(8,479). Is it quite a wrong thing for these children to remain with their parents? Theoretically it is wrong, but practically there is very little danger, and it gives the patients some pleasure in life.

"(8,480). Why do you think there is practically little danger? If a child is in good health there is no danger of contracting the disease.

"(8,505). On the same line of reasoning must we not give up segregation? I do not say give it up altogether. In Norway a man is allowed to live with his family provided he submits to certain regulations, consequently the doctors there cannot think the disease is so dangerous."

THE ISLAND AS A PLACE OF RESIDENCE.

Mr. W. C. de Waal was asked :—

“(8,211). Have people ever complained to you? Yes, most bitterly. They are tired of the everlasting white sand and the monotony. There is nothing for the patients to do. There is also a terrible stench from the sea-weed, and in winter it is dreadfully cold.

“(8,212). Do the patients complain of the cold? Yes, bitterly, and also about rheumatism, a thing which some of the patients never had before, they say.

“(9,217). Would you be in favour of incurring further expenditure on the island or removing the institution to the mainland. Certainly removing it to the mainland. . . . What I say is that as matters stand now it is a hardship to remove persons from their farms and put them on a desert island. It is enough to kill any one, even if he has nothing the matter with him. If I was put there and had nothing to do I would be dead within eighteen months.”

Dr. Henry Clarke, an advocate for isolation, said, respecting the island :—

“It is a terrible place, I think, so bleak and barren. . . . It is a bleak and barren place to confine people in for the remainder of their lives.”

MANAGEMENT OF THE ISLAND.

The Rev. C. S. Morgan (Dutch chaplain on the island) was asked :—

“Do you think it leads to any irritation on the part of the lepers to see policemen walking about with loaded firearms? Many of them do not like the idea.

“(7,700). Do they complain about it? They have not lodged any complaint with me in that respect, but they have said they are worse off than thieves, and they compare their lot with that of the convicts.”

Dr. Impey, medical superintendent, was asked :—

“(6,584). What procedure would you adopt before firing upon the lepers in case of an outbreak? I would not fire on them if I could possibly help it. If they attacked me, or if there was a disturbance among them, I would call out the guards, who have revolvers, and try and quell it in every way. If they commenced to injure the guards I would have to shoot.”

Dr. Jones, one of the medical officers, was asked :—

“(8,427). Under what circumstances would you shoot a man or, suppose a leper was shot, what circumstances do you think would justify it? I think if a guard was assaulted seriously.

“(8,441). Is it not rather out of place, in a hospital devoted to the care of sick people, to have the patients surrounded with armed guards ready to demonstrate their revolvers on any occasion? I suppose Robben Island Asylum is not like an ordinary hospital for curing people, but a place for the segregation of people who are left there practically to die.

“(8,458). You mean that merely showing their revolvers might have a moral effect? Yes. When the Commissioners came over to the island recently they saw that even the female leper patients were in a state of excitement. There were no revolvers drawn on that occasion, though the constables were called out.

“(8,464). We have heard about a threat to burn down Dr. Impey’s house. Do you think there is any fear of anything of that kind taking place? Certain threats were used as regards Dr. Impey’s house. . . . The lepers seem to have an idea that it is Dr. Impey, and Dr. Impey only, who is keeping them on the island.”

OPINIONS OF LEPERS AS TO THE MODE IN WHICH THE DISEASE HAD BEEN CONTRACTED.

The Rev. W. Watkins (chaplain on the island) was asked whether he thought that healthy relatives and friends of lepers might be allowed to live with them “in some kind of settlement,” replied:—

“It would have a very good moral effect, I am sure, and I am told there are very few cases of heredity.”

Mr. Watkins added that he should like to see the Act modified, so as to allow a wife to accompany her husband into exile, and averred his belief that many wives would do so. Asked further:—

“(7,561). Do the lepers ever speak to you as to how they got the disease? I have often asked them, and a great many of them attribute it to exposure. Most of the male lepers have worked on farms; there are comparatively few from towns.”

We have seen that it was on farms that rations of rice and salt fish were usual. Surely a contagious disease should prevail in towns rather than in country places.

“(7,562). Do you think they have generally associated with other lepers? Many of them say they have not.”

Rev. E. G. Nichols said: “I never could get a satisfactory account from either male or female patients as to how they got the disease. They generally said they caught a cold or got a chill.

The Rev. R. Nichols, having been asked whether he thought leprosy contagious, replied in the negative, and went on to adduce cases in which it appeared to have originated from cold and from bathing when heated. He had seen leprosy cases in St. Helena Bay, Stumpnose Bay, and Saldanha Bay, and at Malmesbury and other places. He mentioned particularly the case of a man who lived at the mouth of the Berg river . . . and was born at Simonstown, and was a labourer and a fisherman. He had been a very healthy man until the leprosy appeared (“six months after bathing when heated”).

“(8,085). Had he been living with other people who were lepers ? No.

“(8,086). Who did he live with ? His father-in-law.

“(8,088). What did his father-in-law work at ? He was a fisherman and had his own boats.

“(8,089). Was there a large family in the same house ? Yes.

“(8,090). Were the other members of the family healthy ? Yes, his wife and children were all healthy ; there was nothing the matter with them.”

HOW PATIENTS ARE GOT TO THE ISLAND.

The Rev. S. W. Morgan (chaplain on the island), said :—

“(7,734). In many cases persons in authority were to blame on account of their misrepresentations. Patients, I am told, have been given to believe that there is a large staff of medical men on the island who will place them under certain treatment, and in two or three months they will be cured and able to return home ; whereas, instead of two or three months, some of them have been on the island two years, and the percentage of Free State lepers who died last year was very large.”

Mr. J. C. Faure, a magistrate of Cape Town :—

“(7,426). Who is supposed to report cases ? The Town Council have reported in two instances, and I had them enquired into and certified by the district surgeon.

“(7,427). Had you any difficulty in having the individuals examined ? We set about it cautiously and took care that the patients were not frightened into the idea that they were going to be sent to Robben Island, and immediately the papers were ready we got them.

“(7,438). Suppose it was reported to you to-morrow that A. B., a person of some social position, was supposed to have leprosy, would you send a constable to his house to make enquiries ? I would not mind sending the chief constable to his house ; I would not send an ordinary constable in such a case. You might, perhaps, send the district surgeon with authority to require the suspected person to submit to an examination ? It is rather a serious thing to go to a house and tell a person that he is suspected of having leprosy ; it should be done in as cautious a manner as possible.”

Mr. D. C. de Waal was examined as to the working of the acts.

“(8,185). In some districts the authorities are very active, and on the slightest report they are all up in arms. I know one district where they wanted to remove anyone with a few spots on his face. Dr. Impey himself has said that there are some patients who might safely be allowed to leave the island ; perhaps they only had their fingers crooked. There was one woman on the island who had five children, and she was better than at the time she married ; not one of her children was diseased, but the neighbours got frightened, and so she was packed off.

“(8,186). Did Dr. Impey lead you to suppose that it was not a case of leprosy ? His opinion was that she was absolutely cured.

“(8,187). Who had effected the cure ? Nature, I suppose. In cases of leprosy where there are no sores I cannot think that it is contagious. I had two old coloured men (lepers) working for me on the farm, and their fingers were crooked, but they worked there till the day of their death.”

COLLEGE NOTES.

BY THE DEAN.

THE *Conversazione* on the 4th of this month promises to be a great success. The acceptances reach a large number, and there are requests from many outside of our own membership for cards of invitation.

The formal opening of the Museum will be the occasion of a short ceremony at 8.30 o'clock.

At 9 o'clock Professor Osler, of the Johns Hopkins University, Baltimore, will deliver his Oration, and thereafter the remainder of the evening will be devoted to social intercourse, which will be promoted by music, tobacco, and the class of inner-man comforts that are comprised under that somewhat elastic term "light refreshments."

Many very interesting exhibits are promised, and those of Dr. StClair Thomson, Professor Crookshank, Mr. Freyer, and Mr. Cheetle will specially attract notice. The microscopic sections in the laboratory will well repay inspection, and the Röntgen Ray demonstrations by Dr. Harrison Low will be generally appreciated.

After the completion of Professor Osler's lecture, a succession of Lantern Views will be given in the Library.

* * *

THE *Conversazione* held on May 26, to meet Lord Strathcona and Mount Royal, was attended by a large and distinguished company of upwards of 600 guests. Ladies were very much in evidence and were no less keenly interested in the various scientific exhibits than in the laboratory, museum, and other departments of the College buildings.

Mr. Hutchinson's lecture on "The Story of Robben Island" was so popular that the large lecture-room was much too small to accommodate all who wished to listen to him.

Robben Island will for many a day continue to excite a sympathetic interest in the minds of those who were fortunate enough to hear Mr. Hutchinson's graphic and almost pathetic description

of the unfortunate lepers who form such a large portion of its present day population.

After Mr. Hutchinson's lecture was over, a series of pictures from China and Japan were demonstrated by Mr. James Cantlie. Throughout the whole afternoon Captain Pinch interested a succession of visitors by demonstrating to them the process of Röntgen Ray photography. In the same room Dr. Dundas Grant afforded opportunities for inspecting the mechanism of an electrical larynx, and Dr. Fletcher Little exhibited a sphygmograph with certain new and important modifications of his own, pulse tracings from which were eagerly sought after by many of the ladies.

In the museum were displayed various objects of interest, notably a collection of valuable Indian trophies lent by Sir Joseph Fayrer, a series of interesting photographs contributed by Dr. Theodore Williams, a collection of Chinese and Japanese curios from the collection of Mr. James Cantlie, and last, but certainly not least, a priceless volume belonging to Sir William Broadbent of "Marmion" with an inscription to the Princess of Wales dated 1808, in the handwriting of the author, Sir Walter Scott.

Music was supplied by a small but efficient orchestra, and the proceedings throughout were successful and enjoyable.

* * *

DURING June the Clinical Lectures of the month were delivered by Mr. William Rose and Dr. Ferrier. Both lectures, it is needless to say, were excellent expositions of the subjects with which they dealt. They will be found in abstract form in our present issue and will be read with interest by members who were unable to be present. Arrangements have been made whereby, in future, all our Clinical Lectures will be reported in abstract in the POLYCLINIC.

* * *

CLINICAL Lectures will be delivered during July: on the 4th by Professor Osler of Baltimore, on "The Teaching of Practical Medicine," and on the 18th by Mr. A. W. Mayo Robson of Leeds, on "Chronic Pancreatitis: its simulation of Cancer of the pancreas and its treatment by operation, with illustrative cases."

* * *

DURING the month of May twenty-two consultations were held at which one hundred and twenty-seven cases were investigated.

The total attendances at the College for the month amounted to 1,042, being the highest on record.

* * *

THE Annual Dinner was held at the Trocadero Restaurant on May 31, under the presidency of Lord Strathcona and Mount Royal, one of our Vice-Patrons. Upwards of 150 guests were present. The financial result of the dinner did not much exceed £600, but this sum, though small, must be looked upon as fairly satisfactory when it is considered that the war has this year made serious demands upon all classes of men.

The arrangements concerned with every detail of the dinner were excellent, and Dr. Seymour Taylor is to be heartily congratulated upon the satisfactory outcome of his efforts. He had to work very hard indeed to provide for the comfort of such a large assembly, and there is but one opinion of unstinted and grateful approval at the way in which he fulfilled all the duties of his honorary, and onerous post, in connection both with the dinner and the preliminary conversazione.

* * *

At the last meeting of Council Mr. Jonathan Hutchinson and Mr. Malcolm Morris were respectively chosen to occupy the positions of Chairman and Vice-Chairman, rendered vacant by the recent resignation, for health reasons, of Dr. Miller Ord and Dr. Stephen Mackenzie.

Both Dr. Ord and Dr. Mackenzie remain members of Council.

The creation of the office of Dean caused a vacancy which, at the same meeting, was filled by the appointment of Sir William Kynsey.

* * *

WHAT a life of activity and adventure has been that of Sir Joseph Fayrer! His autobiography, which has just been published by Blackwoods, is a fascinating record of a life that seems scarcely to have known an idle moment, and which, we are glad to know, is still full of energy and work. Sir Joseph's reminiscences will well repay perusal and are sure to be widely read, not only throughout the profession, but by the general reading public.

* * *

SIR WILLIAM GAIRDNER's lecture on "Clinical Memories" (of which a report is given at page 15) was a happy collection of odd

events and striking cases gathered from an unusually extensive field of valuable experience. Unluckily the date of this lecture fell upon Derby Day, a fact which considerably diminished the size of the audience; nevertheless there was a well-filled room, and many old pupils of the popular Glasgow professor came to listen once again to the voice of the master. Sir William Broadbent presided, and in a few well-chosen sentences moved a vote of thanks which was cordially responded to.

* * *

THE Council have sanctioned an increase in the Laboratory equipment. The class on Clinical Microscopy has proved so popular that it has already outgrown its modest beginnings and facilities for a larger class have become imperative. This is a very gratifying tribute to the value of Captain Pinch's tuition, and one upon which we are all glad to congratulate him.

* * *

THE College Library has recently been enriched by several valuable contributions, from our members, of books and portraits.

The Honorary Librarian much appreciates this generosity and hopes such a good example will not fail to stimulate others to go and do likewise.

* * *

DR. BOWLES' three lectures, to be delivered in July, may be confidently expected to be of great interest since he is known to have devoted much attention to the subjects with which he will deal. On the resuscitation of those drowned he has long been an authority, and his very practical suggestions as to the importance of posture during coma and after anæsthetics, &c., have been widely adopted. His lectures will, we understand, deal with the experimental evidences connected with the subject of drowning, and those on artificial respiration connected with the various methods for resuscitation as well as with different forms of apnoea, asphyxia and comatose conditions. The short title given on the card does not adequately describe their scope.

MUSEUM NOTES.

Unilateral Ichthyosis—Biett's Bands.

By accident we omitted the woodcut showing the front aspect of Mr. F. Mackenzie's case, of which we gave a short notice in the May number. We now supply it.



THE new Museum, of which we gave plans in our first number, and which has been erected on one side of the College buildings, is now complete and ready for occupancy. It has in fact, already to a

large extent been occupied; its walls being well covered with drawings, &c. As has been explained, it will be designed almost exclusively to assist in diagnosis and treatment, and may be regarded as a clinical rather than a pathological collection. No attempt whatever will be made to include Natural History or Comparative Anatomy. Human anatomy will be illustrated so far as the objects, drawings, models, &c., can be made directly useful to the physician or surgeon in his daily work. Pathological specimens will be collected for purposes of teaching, that is such as can be used in lectures, but they will for the most part, at any rate for the present, be kept in open receptacles, and not permanently mounted. It is thought by the Museum Committee and the Council that the great collections of specimens in pathological anatomy which have been accumulated at the Royal College of Surgeons, and in connection with most of our large Metropolitan Hospitals, leave but little that needs to be done in this branch. They are easily accessible to all investigators. On the contrary, but little has as yet been done in the attempt to illustrate by pictures and models the external phenomena of disease, and to give facilities for the study of such symptoms as are revealed to the eye. It is, therefore, to this department that our Museum will be, in an especial manner, devoted.

The Museum is entered by two doors, one to each floor. What may perhaps be regarded as its principal entrance, leads from the hall of the college to its upper floor or gallery, and the visitor must descend a staircase to reach the ground floor which, of course, constitutes its chief room. This somewhat awkward mode of access was unavoidable, and although it certainly detracts from the appearance, will in no way diminish its usefulness. For the present the objects displayed have been put in order only on the upper floor (or the gallery), and to this we now propose to conduct our readers.

THE DERMATOLOGICAL COLLECTION IN THE MUSEUM GALLERY.

On entering the Museum Gallery by the side door and turning to the left the visitor will begin with the great natural group of diseases of the skin, in which the cause is either wholly or chiefly one acting on the surface from without.

DISEASES OF THE SKIN DUE TO EXTERNAL CAUSES.

This great group comprises Scabies, Psorospermosis, Molluscum contagiosum, eruptions due to lice, fleas, &c., those caused by tar, lime, sugar and other irritants. We have also the Tineæ, Pityriasis rosea, and the contagious forms of Prurigo, Impetigo, and Eczema. Portraits illustrating these and a few other allied forms occupy the whole of the side of the gallery to the left of the door and the whole of its south end.

Scabies.

In this series we have :

- (i.) Erasmus Wilson's portrait of the arm and hand of a child.
- (ii.), (iii.), and (iv.) Portraits from Hebra's atlas.
- (v.) A portrait from Cazenave, showing great œdema of the arm of an adult.
- (vi.) An original water-colour, by Burgess, showing like the preceding, great swelling of the hand and arm.
- (vii.) The plate published by Danielsson and Boeck showing the very severe condition of chronic dermatitis, occasionally seen in connection with neglect.
- (viii.), (ix.), and (x.) Portraits from other sources.

Molluscum Contagiosum.

Beginning with Bateman's original portrait, we have probably an unrivalled series of delineations of this curious malady, most of them original, by Burgess.

- (i.) Bateman's portrait, the original delineation of molluscum, showing the little buttons on the face of a child and one which has inflamed and become prominent on the eyelid.
- (ii.) Erasmus Wilson's portrait, the face of a child.
- (iii.) An original, showing the eruption on the face of an infant and also on the breast of its mother.
- (iv.) Ditto, showing a patch on the side of the forehead of a barber, who had infected himself by his comb.
- (v.) Ditto, showing the buttons around the anus of a child.
- (vi.) Another showing the same, but much inflamed, so that the character of the buttons was concealed.

(vii.) One showing a very large button close to the nipple of a nursing mother, which had been mistaken for a chancre.

(viii.) Ditto, showing a molluscum button on the eyelid which had inflamed. (Compare with Bateman's.)

(ix.) A large original portrait showing an extensive group of small molluscum buttons on the shoulder of a man who had used the Turkish bath.

(x.) The arm of a man in whom the eruption had occurred under similar conditions to the preceding, and in whom the buttons were many of them very small and might have been mistaken for those of lichen.

(xi.) and (xii.) Hebra's published portraits showing the disease on the neck of a woman, and the genitals of a man.

It may be remarked that with the exception of the last named, none of the continental atlases contain good portraits of molluscum contagiosum.

In one of the swinging-frames are to be found lithographs, &c., illustrating the naked-eye and microscopic anatomy of the molluscous growths from Bristowe, Fox, Sangster, and others.

(To be continued.)

COMMITTEES OF INVESTIGATION.

Standing Committee on Leprosy.

A MEETING of the Standing Committee on Leprosy will take place on Wednesday, July 11, at 5.30. Dr. Radcliffe Crocker, the chairman of the committee, will preside, and will introduce the discussion. The topic is *Leprosy as observed in English practice*, that is in immigrants from leprosy districts. The experience of those present will be asked for on the following points:—

(1) The place of origin and probable source of acquisition in each case.

(2) Whether any suspicion of contagion occurred in England, and what precautions were adopted.

(3) The progress of the disease and the results of treatment.

(4) The number of cases observed.

This committee consists of the following :—Dr. Radcliffe Crocker (chairman), Sir William Kynsey, Dr. Abraham, Dr. Oswald Baker and Mr. Hutchinson (secretary, *pro tem.*), but all members of the Polyclinic are invited to attend and assist, and written communications from those who cannot be present will be acceptable.

NEW DRUGS AND ARTICLES OF DIET.

PLASMON.

Under the name of *Plasmon* we have had submitted to us a product of milk which has already obtained a good reputation. Plasmon is a white powder, which so long as it is kept dry does not decompose or alter in any way. It contains the albuminous elements of milk without the sugar and fatty matters. Its advantages over extracts of meat are its flesh-forming qualities, its cheapness and its freedom from tendency to decomposition. Over milk itself it has the advantage not only of being in small compass but in many states of disordered digestion more easy of assimilation. Thus it will be seen that for many states of impaired health, when saccharine and fatty matters are apt to cause acidity, we have in it a most useful substitute for milk. It may prove of great service in infantile eczema and other maladies in which milk itself often seems hurtful. It is, we understand, prepared in England as well as in Germany, and the important elements which are abstracted are, of course, put to good use. Hence the cheapness of Plasmon.

KAPUTINE.

Under the name of “Kaputine” a remedy is being advertised for the relief of headaches, and is, we believe, coming into rather extensive use. Its efficacy in many forms of neuralgia is certainly very remarkable. Probably, however, it does not differ much from other drugs, the nature of which is not secret. An analysis of it, which has been made for us by Mr. Martindale, shows that a principal constituent is antifebrin. Whether “Kaputine” is free from the risks which attend the use of the latter is, of course, very

doubtful, and medical men who are asked concerning it will do well to reply very cautiously.

Antifebrin is acetanilide. In the form of "Kaputine" it is a dry crystalline powder, which you are instructed to put on the tongue and wash down with water. It is coloured pink with an iron oxide.

CORRESPONDENCE AND ANSWERS.

DR. McWILLIAM, who accompanied one of the earliest Niger expeditions (that of Captain Trotter), mentioned at a meeting of the Geographical Society in 1858 his experience that a residence in England made blacks liable to fever who would not have been so had they remained in their native land. He stated that out of 108 negroes who entered the service at Sierra Leone not one was attacked. Out of a total of 132 blacks who were employed only eleven were attacked and none of these died. All the eleven had lived some years in England. In the light of modern knowledge it may be plausibly asked whether there is anything in English food, &c., which renders those who have used it peculiarly attractive to the mosquito. Do mosquitoes attack negroes?

* * *

In the Murchison range of Northern Transvaal it is reported on the authority of Mr. Sawyer, who had lived there two years, that "the winter is pleasant and healthy; there is but little rain, the days are hot, but the nights cold. Great changes of temperature are experienced at all seasons, which, without proper precautions, cause fever and other sickness." Mr. Sawyer holds that "though there is danger of catching fever during the rainy season, immunity can be secured by attention to ordinary rules of health; by retiring at sunset, not rising too early, abstaining from spirituous liquors, and choosing a high residence." He quotes instances of Europeans living there for years without being attacked. "The fever," he adds, "is said to be a climateric intermittent, not strictly malarial like that contracted in other parts of the district, and rarely proves fatal if proper attention is given."

* * *

THE "COLAR-NUT" is a bitter pink kernel brought from Sierra Leone. It is an excellent tonic, and is so preventive of thirst that a Jodoff having one in his mouth will walk thirty miles without drinking water.—Napier Hewitt, *Geographical Transactions*.

* * *

SLAVERY IN THE FREE STATE WHEN UNDER BRITISH RULE.—"The master, like most of the Boers, had gone to the Sand River Meeting, but several native children were pointed out to me on the farm as having been seized by the Boers on a recent commando, with a number of others, all of whom were distributed among the farmers for slaves. This practice, I was given to understand, was quite common, not merely among the Boers beyond the Vaal, but in the Sovereignty itself." [At this date, 1857, what is now the Free State was "a British Sovereignty" under English rule.]—Sanderson, *R.G.S.* xxx.

COLLEGE LECTURES AND CLASSES

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

PRACTICAL CLASSES.

| | | |
|--------------------------------|--|----------------------------------|
| | | (Seymour Taylor, M.D., M.R.C.P. |
| Applied Anatomy (Medical and | | J. Edward Squire, M.D., M.R.C.P. |
| Surgical), Physical Diagnosis | | James Cantlie, M.B., F.R.C.S. |
| | | Albert Carless, M.S., F.R.C.S. |
| Clinical Examination of the | | (James Taylor, M.D., F.R.C.P. |
| Nervous System | | Harry Campbell, M.D., F.R.C.P. |
| Practical Ophthalmology: the | | (E. Treacher Collins, F.R.C.S. |
| use of the Ophthalmoscope | | W. Holmes Spicer, M.B., F.R.C.S. |
| and Refraction | | John Griffith, F.R.C.S. |
| Practical Otology | | (J. Dundas Grant, M.D., F.R.C.S. |
| | | Richd. Lake, F.R.C.S. |
| Practical Rhinology and Laryn- | | (StClair Thomson, M.D., F.R.C.S. |
| gology | | Herbert Tilley, M.D., F.R.C.S. |
| | | W. Jobson Horne, M.B., M.R.C.P. |
| The Application of the Röntgen | | |
| Rays | | F. Harrison Low, M.B. |
| Clinical Microscopy | | A. E. Hayward Pinch, F.R.C.S. |

COURSES OF LECTURES.

| | | |
|-----------------------------------|-----|------------------------------------|
| General Ophthalmology... | ... | R. Marcus Gunn, M.B., F.R.C.S. |
| Lectures and Demonstrations on | | |
| Diseases of the Skin ... | ... | Phineas S. Abraham, M.D., F.R.C.S. |
| Administration of Anæsthetics ... | ... | J. F. W. Silk, M.D. |
| Diseases of Children | ... | G. F. Still, M.D., M.R.C.P. |

CLASSES IN ASSOCIATION WITH THE COLLEGE.

| | | |
|-------------------------------|-----|-----------------------------------|
| Practical Bacteriology | ... | Professor Crookshank, M.B. |
| Mental Diseases | ... | Maurice Craig, M.D., M.R.C.P. |
| Hygiene and Public Health ... | ... | A. Wynter Blyth, M.R.C.S., F.C.S. |

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, W.C.

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. III., No. 8.—AUGUST, 1900.

OUR NON-RESIDENT MEMBERS.

ALL members of the Medical Profession are eligible, on approval by the Council, as members of the Polyclinic. The subscription for all is one guinea annually.

At first sight it might be thought that the Polyclinic offers but few attractions to non-resident members. We hope, however, to show that this is a great mistake. At present our members' list numbers nearly 700 names, and some of us believe that if the advantages offered to non-residents were well understood it might easily be extended to as many thousands and with advantage both to the institution and to the profession. We will endeavour briefly to state the attractions which are offered to this class of our members:—

(I.) They are entitled, whenever they may chance to be in town, to attend the Consultations and Clinical Lectures. Between the hours of 4 and 6 on five days of the week either one or the other will always be found going on.

(II.) They are entitled to send or bring patients for consultation (if suitable cases).

(III.) They receive the Journal, which is published monthly, and which is designed as a record of the clinical work of the institution, and may be expected to take its place as one of the foremost medical

journals of the day; for the amount of good material at its disposal is very large indeed. The cost of this journal to non-members is twelve shillings, and it therefore makes up the larger half of the annual subscription.

(IV.) They have access at all times to the Library. There is a large collection of periodicals and books, and there are comfortable rooms for reading and writing. On a minor scale, the College may be said to supply the conveniences of a club, for letters can be addressed there, certain refreshments can be had, and in one of the reading rooms smoking is permitted.

Amongst the more legitimate attractions of the Library may be mentioned the unique collection of 136 Extract Books. These constitute a feature possessed by no other library, and are invaluable to all engaged in research, and more especially to those residing at a distance and desirous to make many references in a short time.

(V.) They have access at all times to the museum. This part of our institution is already in working order. It contains classified illustrations of disease, more especially in its external forms, and affords opportunities for clinical study on a scale which might perhaps be sought in vain elsewhere. There will soon be collections of instruments and appliances, and no effort will be spared to make the collection one which the busy practitioner may resort to with assured advantage. Within its walls at any hour of the day, by the aid of the "Companion-Catalogue," which is in course of preparation, the visitor will, we trust, be able to learn more in certain subjects than by ten times the amount of time and attention given to books. It will be, we trust, a place for real study, which ought to be visited again and again.

(VI.) They are entitled to attend all meetings of our Standing Committees of Investigation. These committees as at present appointed deal with some of the most important practical questions of the day, *e.g.*, Tuberculosis, Leprosy, Climate, &c., &c. All their sittings are "open," and all members are eligible for appointment to them.

In what we have mentioned above are comprised the chief privileges which are included in the subscription, and we think it will be admitted that a good guinea's worth is offered. The College has various other departments which are open to its members, but for

which additional charges are made. There are its Teaching Classes in various subjects, and its Laboratory. To the latter, at a low scale of charges, members are allowed to send or to bring specimens for examination and report.

ASSOCIATION OF HOSPITALS.

THE original plan of those by whom the Polyclinic College was organised comprised a Hospital as part of its scheme. At one time negotiations were considerably advanced for the purchase of a large site which would have allowed of the erection of suitable buildings. It is, perhaps, in some respects to be regretted that this plan was not carried out and that the institution was commenced in premises which, although adequate for all teaching purposes, do not supply any ward-accommodation. All the great Polyclinic Institutions on the Continent and in America have large hospitals in connection with them, and no one doubts that opportunities for ward-study are as important for post-graduate instruction as they are for that of younger students. Our change of scheme, however, proceeded from motives which were, at any rate, good ones. It was desired not to increase to any greater extent than was unavoidable the demands made upon public charity, already in the matter of hospital support somewhat strained. At the same time it was believed that by association with existing institutions yet better and more extended opportunities might be secured than could be got by building a new hospital. London abounds in medical institutions of the most varied kind and the waste of opportunities for clinical study is enormous. This waste concerns not alone the interests of a large number of practitioners who would, were these opportunities open to them, very gladly avail themselves of them, but is a serious retardation of the progress of medical science itself. In the attempt to carry out our modified plans, however, certain difficulties arose in securing the co-operation of the larger hospitals on the terms on which we desired it.

It is necessary in the first place to explain that we have throughout held firmly to the principle that the instruction suited for students is not the same as that adapted to the wants of graduates, and that the two classes ought to be taught apart. We have, perhaps, pushed this too far, and at any rate it has proved the rock which has barred our way in our negotiations with the large hospitals which have schools attached to them. The reply from them has been that it would be injurious to their interests to form classes from which their students should find themselves excluded, and, further, that the energies of their teachers are already sufficiently taxed. As regards these hospitals, therefore, there seems little hope of securing special post-graduate teaching, but there is yet room for hope that they and the Polyclinic may be made very useful to each other. It would be an advantage to the members of the latter, and especially to those who are strangers in London, if a general ticket could be offered them, for a moderate payment, which should entitle them to visit such hospitals as had associated themselves with us. If, on certain days, it might be announced that special efforts would be made in the direction of advanced clinical teaching so much the better; but even without this the issue of an inclusive ticket for several different hospitals would be a boon to many graduates, whilst to the hospitals it might save much trouble, and materially increase their usefulness.

If, however, as regards the hospitals which have schools attached, we are for the present obliged to surrender the principle of separate classes for non-graduates and graduates, there yet remains a large group of institutions in which it is not necessary to do this. There are within the London area several large general hospitals which have no schools. One of these has, it is true, already a well organised and successful post-graduate scheme, but several others might easily be named in which, if any such arrangements exist, they are probably in a very embryonic condition. If an invitation which our Council proposes to extend to these, and to many other Special Hospitals, Dispensaries and Sick Asylums should be widely accepted it may be practicable to secure by means of thoughtful arrangements very excellent opportunities for clinical observation to all post-graduates who may join us. At the same time we should be able to send to the associated institutions at appointed times

groups of intelligent and already educated pupils, whose presence could not but serve as a healthy stimulus to the teachers' zeal. Fees would of course be charged, but they must be moderate, and, for the present at any rate, it is not probable that the direct money incentive would be great. It is not, however, always the case that the best work is done for payment, and there are, perhaps, not many in our profession to whom the consciousness of assisting in medical education and in advancing medical knowledge is not a far more potent motive to exertion. To this, it may also be fairly added, that the attempt to convey clinical knowledge to men already fairly well taught, is a most helpful exercise to the teacher himself.

The details of the proposal which the Council of the Polyclinic will probably make to the institutions which we have designated will be that they should severally undertake to receive our members on certain fixed days. It may be that these visits will be made once a week or once a fortnight only, but possibly much more frequently. The frequency of the visits will depend upon the character of the institution and the zeal of those concerned. It will be asked that on the occasion of the attendance of our class some special effort be made in the direction of clinical instruction. We shall not ask for formal clinical lectures—these are more conveniently delivered in our own theatres—but rather that selected cases be brought forward and clinical comments upon them offered. Opportunities for observation, in the operating theatres, of the use of anæsthetics and the details of operations will be much valued. Nor will admission to the *post-mortem* room fail of appreciation. It will, however, be left optional with the institutions which may associate themselves with us whether they prefer simply to admit our graduates to the ordinary practice of their out-patients' rooms, wards, and theatres, at all suitable hours, or to make the more special arrangements which have been referred to. In many cases simple admission to see the practice may be all that is desirable.

When our list of Associated Institutions is completed it is proposed to issue a general ticket of admission to the whole, and also to prepare other tickets for divided groups classified either by locality or according to their special character.

ASSOCIATED PUBLICATION OF HOSPITAL REPORTS.

ALTHOUGH by no means a part of the arrangements suggested in what has been written above, we have to ask attention to another direction in which it is possible that the work of the Polyclinic may be made useful to the Hospitals which may become associated with us. We refer to our Journal. This Journal is issued monthly, and has a guaranteed circulation of 2,000 copies, and will in the future, we hope, realise a much larger one. It is printed in a form well suited for permanent preservation. Now a large majority of the medical institutions of the metropolis publish no reports of a clinical character. Guy's, St. Bartholomew's, St. Thomas's, and St. George's publish annual volumes, which are invaluable as repertories of clinical facts and as preventing the loss of the year's observations. It is impossible, however, that all the other hospitals should follow this excellent example, and if they did so a great waste of labour would result. Such Reports have necessarily only a limited circulation. They go, it is true, to all public libraries, but beyond this most useful destination they are probably sent almost exclusively to the former pupils of the hospitals which they concern. Now we would venture to propose to the other institutions which at present issue no "Reports" that they should secure once a quarter, or half-yearly, or yearly, a sheet in our POLYCLINIC for a record of their statistics and more important cases. Such records would thus obtain a good circulation and would become permanently accessible. It is the design of the POLYCLINIC that it should keep closely to clinical subjects, and records of the kind referred to would find a most appropriate place in our pages. There is no Hospital or Dispensary but what ought, once a year at least, to give a summary of its experience. We do not mean a dry tabulation of names of diseases and numbers of cases, but a living record of the year's practice, with more or less detailed references to the less usual facts which had come under notice.

It would not be difficult to suggest certain methods of statement which might secure a degree of uniformity and thus gain some of the objects of "Collective Investigation."

EQUALISATION OF OUR MEMBERSHIP FEE.

OUR rules as to membership in the Polyclinic College made for a time a distinction between residents within the London district ("Churchill's Directory") and those outside it. The subscription for non-residents was one guinea a year, whereas for residents it was two. One of the reasons for this difference was that the Council was desirous to secure the consultation rooms from overcrowding, and it was supposed that residents in London would take advantage of their privilege in this matter much more frequently than those residing at a distance. On the other hand it is to be remembered that Londoners are at home, near their daily work, and therefore more liable to be prevented by casual occupations than are those who have come up to town for a special purpose. On the whole we feel assured that the Council has acted not only generously, but wisely, in deciding to reduce the subscription for residents, and thus place all on an equality. To have maintained the two guinea subscription would have kept down the number of resident members, and would thus have diminished the usefulness of our Institution. It was, besides, a somewhat arbitrary and invidious distinction, and cases would from time to time have occurred in which men living within half a mile of each other were required the one to pay one guinea, and the other two. It is, therefore, with much pleasure that we announce that by a recent decision of the Council the subscription is henceforth a single guinea for all.

PROPOSED SOLUTION OF THE LEPROSY PROBLEM.

It is not easy to devise experiments which should set at rest the question between contagionists and dietists as to the cause of leprosy. The sentimentality of the age would call it inhuman to supply the inmates of a jail with dried fish if it were done by one who believed that it might produce leprosy. If, however, the same diet were given without ulterior object nothing would be said. If, therefore, some zealous contagionist, who has no misgivings as to fish, would undertake the matter, we might obtain very valuable results without scandal. He would be able to say from his heart that he did not think any harm would come, that, indeed, he felt sure that it would not. The trial might be made on some prison containing a hundred or more convict Boxers, and should extend over at least several years. The diet should be mainly rice, with an *ad libitum* supply of salted and dried fish, and of any condiment made of fish that was in use in the district. Fresh vegetables and other articles might be liberally supplied, but the staple articles should be the two named. Rice is a tasteless food, and gives appetite for salt and savory additions, and it is especially amongst rice-fed populations that a small quantity of fish appears to be efficient for the production of leprosy. The fish should, of course, be supplied uncooked, and cured only according to the methods in use in leprosy districts. In order to furnish a standard for comparison another hundred convicts of the same class should be fed on the same diet with the substitution of flesh meat for fish, and the total exclusion of the latter. If under such conditions the one jail supplied a liberal percentage of lepers, and the other only very few, a lesson would have been learned which might become the means of saving many lives and preventing a vast amount of misery.

There does not appear to be any object in trying more experiments as regards the inoculation of leprosy, even if such were legitimate. Already enough has been done to prove that the disease is not easily transferred, and it is not necessary to do more. The demonstration that once in a thousand times inocula-

tion might succeed, even if it were obtained, would not much concern our opinions as to the nature of the malady. Such a possibility may be freely conceded even by those most firm in the belief that the ordinary mode of production of the disease is by food and not by contagion. As yet all experiments by inoculation—and they have been many—have failed. We put aside the case of Keanu, since it is open to the obvious fallacy that the man experimented upon was of a leprous family, and was also himself fed on the suspected food.

We take the following from our contemporary "*Tuberculosis*":—

THE HIGH DEATH-RATE FROM PHTHISIS IN WALES.—The little principality of Wales has the unenviable distinction of having a very high death-rate from phthisis. North Wales has a higher rate than any county in England, while the rate in South Wales is only exceeded by that in Northumberland. The mortality is especially high in the westerly and more mountainous parts of the country. Carnarvon (the registration district) had a death rate of 2·89 per thousand for males, and of 3·04 for females during 1881-90, and in Cardiganshire the rate was 3·06 per thousand for males, and 2·45 per thousand for females, while for the whole of England and Wales during the same period the death rate was 1·8 for males and 1·6 for females. It seems remarkable that such a sparsely populated country should suffer in so high a degree from this plague. In Carnarvon there are two acres, and in Cardiganshire from five to twelve acres for each person, while in London there is but one-fiftieth of an acre to each individual.

* * *

MOUNTAIN RACES ALMOST EXEMPT FROM PHTHISIS.—In the same number of the same Journal from which we have taken the above, the following, from the pen of a high authority, occurs: "It is well known that mountain races are noted for large chests, which are often out of proportion to the rest of the frame, and their powers of endurance in walking and climbing are largely attributable to this peculiarity; but another feature of these races is their almost total exemption from tuberculosis, which, though it has been partly explained on the ground of their open-air life and freedom from overcrowding, must also be attributed partly to their perfect thoracic development."

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ABSTRACT OF A LECTURE ON JACKSONIAN EPILEPSY.

BY DAVID FERRIER, M.D., LL.D., F.R.S.

“WHAT I propose to do,” said Dr. Ferrier, “is not to attempt anything in the shape of an eloquent or elaborate lecture on the subject of Jacksonian epilepsy, but rather to speak in a purely informal fashion about the salient features of that condition.” Free from the trammels of a manuscript, and in an easy conversational style, Dr. Ferrier then proceeded with his subject, readily carrying his audience from point to point. The following is merely a brief *resumé* of the principal propositions which formed the text for the lecturer’s remarks.

The essence of Jacksonian epilepsy is the occurrence of unilateral convulsions dependent on organic disease in the cerebral hemisphere of the opposite side, and occurring without, or in some cases with, loss of consciousness. Idiopathic epilepsy, on the other hand, is distinguished by loss of consciousness, sometimes associated with, sometimes developing without, convulsions; and there is no definite morbid, structural change to account for the convulsions.

The name is given in honour of Dr. Hughlings Jackson, who first taught that unilateral fits in organic brain disease resulted from the direct action of the lesion upon the cerebral cortex. He suggested that certain convulsions had a motor function, and in this way took the first step towards the establishment of the modern doctrine that different areas of the brain have different functions to perform—a position now secured by actual experimental demonstration.

It must be remembered that all epileptiform convulsions depend

on discharges from the nerve-cells of the motor convolutions grouped about the fissure of Rolando, and that such discharges may be provoked in various ways as, *e.g.*, by reflex irritation, by the presence of poisons in the blood, &c. To constitute Jacksonian epilepsy, however, the discharges from the cerebral cortex must be excited by the direct irritation of organic disease affecting the convolutions.

The feature in the convulsions which shows them to be the result of a localised irritating lesion is the fact that the seizure always commences in, indeed may be restricted to, a particular group of muscles. In the great majority of cases the area of irritation spreads from the centres first affected to neighbouring centres, and the direction of extension is determined by the anatomical relationships of the motor areas. The extension may not be confined to the side first affected, but may cross to the opposite side of the body, and so lead to widespread convulsions. As a rule, when the seizure has extended to the whole of one side (hemispasm) the patient loses consciousness, but here it is to be noticed the loss of consciousness follows the convulsive seizure, whilst in idiopathic epilepsy the patient suddenly becomes unconscious and is then thrown into convulsions.

In order to diagnose the exact site of the lesion it is most important to observe exactly where the spasm commences, as this indicates the centres which are subject to direct irritation. Thus a spasm commencing in the muscles of the arm announces the fact that the lesion involves the arm-centre of the opposite hemisphere. But a more precise localisation would be obtained if exact observation were made of the particular group of muscles first affected in the convulsion. For whilst the lower part of the centre controls the distal movements of the limb, the upper part is associated with the movements of the proximal parts, and hence the recognition of the commencement of the fit in one or other of these situations would lend exactness to the anatomical diagnosis—a matter of the first importance in the view of possible operative interference.

A second guide in localising the exact site of the lesion is obtained from watching the manner in which the convulsion spreads. From the anatomical situation of the centres a seizure commencing in the face must almost inevitably extend first of all to the upper,

and then to the lower limb. Similarly when the fit commences in the lower limb it must needs involve the upper limb before it reaches the face. But involving the arm-centres as a starting point the irritation may travel either downwards to the face area, or upwards to the area governing the lower limb, and thus the direction in which the convulsion extends when it commences in the arm may vary. The constancy of the order in which the various groups of muscles become involved is an important feature in the diagnosis of Jacksonian epilepsy, and may give some help in the localisation of the lesion.

The third aid to the diagnosis is the recognition of weakness more or less marked in certain muscular groups. The abnormal discharge of nerve energy under the irritation of some morbid product, such as a syphilitic thickening of the membranes, a tumour, a spicule of bone, &c., is naturally followed by exhaustion of the centres, and sooner or later by some permanent destructive changes in the cortex, and these express themselves in the shape of loss of function, that is muscular weakness. Therefore the diagnosis of Jacksonian epilepsy is greatly aided when it is recognised that the convulsions in any given case, not only always commence in the same muscular group, and follow on all occasions the same sequence, but when further it is found that the fit is followed by muscular weakness, usually of the part first affected. The same fact also is of great value in securing the exact localisation of the lesion.

In the same direction also is the significance of pain at a particular spot on firm pressure over the scalp. This may be absent in the case of a deeply seated tumour, but in the case of a growth approaching, or actually reaching the surface of the cortex it is nearly always present, and its site usually indicates with great exactness the situation of the lesion. If the symptoms, therefore, suggest a localised lesion in a particular part of the brain, and the tender area is found in the corresponding situation, the diagnosis is almost certainly secure.

The treatment naturally suggested by a diagnosis of a localised lesion affecting the cerebral cortex is removal of the lesion by an operation, and this, when the possibility of localisation first became an accomplished fact, was looked to with great hopefulness. In many cases that expectation has been realised, and the operation

has been followed by a complete cessation of the fits. But unfortunately this is not always the result. The epileptic habit once established tends to persist, even when the original cause of the habit has been removed. This, however, does not contraindicate operative treatment. It rather teaches the importance of prompt operation that is as soon as the diagnosis is made, and the necessity of giving a guarded prognosis more especially in those cases in which a prolonged history of convulsive seizures gives rise to the fear that abnormal discharges from the nerve cells may continue even after the source of the original irritation has been taken away.

It is of interest to note that localised lesions of sensory areas on the brain surface may give rise to discharges of nerve energy which express themselves in the patient's consciousness as sensations. Thus a lesion involving the occipital lobe may cause a visual sensation, and one affecting the temporo-sphenoidal lobe may equal an auditory sensation. Similarly sensations of taste and smell may result when the centres associated with these sensations are the site of tumours or other morbid products. Such sensations and hallucinations correspond in the sensory area to the muscular spasms which follow a localised lesion of the motor portions of the cerebral cortex.

Dr. Ferrier's lecture was illustrated by the attendance of a patient in whom muscular weakness as well as local scalp tenderness was present.

ON THE DIAGNOSIS AND OPERATIVE TREATMENT OF THYROID ADENOMATA.

BY JAMES BERRY, B.S., F.R.C.S.

Delivered May 28, 1900.

GENTLEMEN,—Not quite fifteen years ago, at the final examination for the Fellowship of the Royal College of Surgeons, a candidate made use of the term “thyroid adenomata.” The examiner replied that he had never heard of such things and did not know that they existed!

I mention this incident to show that knowledge on this subject was not at that time very widely diffused. It is very different at the present day, when every surgeon is familiar with thyroid adenomata and most operating surgeons have had to deal with them at one time or another.

The increasing interest which is being taken in the subject is my excuse for addressing you upon it this afternoon.

A thyroid adenoma may be defined as an encapsuled mass of atypical thyroid tissue, imbedded in the thyroid gland. There are three principal forms of thyroid adenoma—the foetal, the cystic, and the so-called malignant.

THE FŒTAL ADENOMA is met with chiefly in children and young adults, and is composed, as the name implies, of tissue resembling that of the normal foetal thyroid. To the naked eye it presents a solid homogeneous appearance. Microscopically it is composed chiefly of solid masses of epithelial cells, representing undeveloped thyroid vesicles. There is little or no colloid material. These adenomata seldom attain a large size. The largest that I have myself met with was about as large as an orange.

They are chiefly of importance on account of their great vascularity. Operations for their removal are apt to be attended by smart hæmorrhage.

THE CYSTIC ADENOMA is by far the most common form. A large proportion of the familiar swellings in the neck known as goitre are

composed wholly or in part of cystic adenomata. They differ from the preceding in containing numerous cavities visible to the naked eye. Their structure resembles that of the normal thyroid, but the vesicles are usually more irregular and show a tendency to run one into another owing to the breaking down of the intervening tissue. The connective tissue between the vesicles is usually more abundant than in the normal thyroid. Cysts of various sizes are seen in the tumour. They contain colloid matter and frequently blood.

The so-called "MALIGNANT ADENOMATA" are much rarer than either of the two preceding. In general appearance these tumours closely resemble that of innocent adenomata, but they differ from them in possessing a tendency to recur after removal and to disseminate. As from their rarity they are of but little practical importance; I do not propose to say anything more about them.

Foetal adenomata and cystic adenomata may be discussed together. It is my belief that the former often develop into the latter.

Many adenomata, having attained a certain size, remain stationary throughout the remainder of the life of the patient and cause no further trouble.

Others, perhaps the majority, tend to become slowly larger.

SECONDARY CHANGES.

All adenomata have a marked tendency to undergo *secondary changes*, some of which are of much importance.

(1) They may BREAK DOWN AND LIQUEFY in the centre, and thus become converted into cysts. There is but little doubt, I think, that the great majority of thyroid cysts that we are called upon to treat have originated in this manner from pre-existing solid adenomata.

I have before me three specimens illustrating this transition from solid adenomata to cysts. The first specimen (fig. 1), taken from a young girl, shows a tumour solid everywhere except in the centre, where there is a small irregular cavity. The next (fig. 2), from an older patient, is similar, but the central cavity is very much larger and composes one-half of the bulk of the tumour. The third specimen, from an elderly woman, shows the last stage. There is a thick fibrous cyst wall and on the inner surface of



FIG. 1. From a girl aged 10.

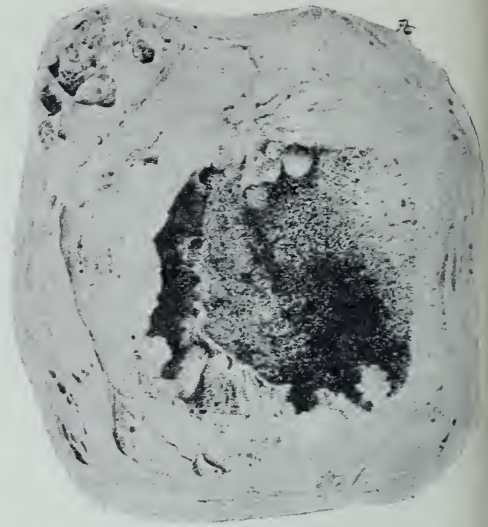


FIG. 2. From an older subject.



FIG. 3. From an elderly woman.

FIGS. 1, 2 & 3.

Three specimens illustrating the gradual transformation of a solid thyroid adenoma into a cyst.

this are seen numerous small masses of solid adenomatous tissue, the last traces of the adenoma which originally filled what is now a huge cyst.

Here are two more specimens. Each is a large goitre containing numerous adenomata; some of these are solid, some have been wholly converted into cysts, while many others show intermediate stages.

Finally, I show you a microscopic slide of a complete section taken through a small thyroid cyst. At two places on the inner surface of the cyst wall are traces of adenomatous tissue. I desire to draw your attention especially to the presence of this soft and vascular adenomatous tissue in the interior of the thyroid cysts since it is the source of the hæmorrhage that so frequently takes place into these cysts. This hæmorrhage may occur spontaneously, and is often produced by injury such as tapping. Every one knows that if a thyroid cyst has been tapped and clear fluid withdrawn a second tapping of the same cyst will often give exit to blood-stained fluid or even pure blood. On many occasions this intracystic hæmorrhage has led to serious results, and it constitutes to my mind a distinct objection to this practice of tapping thyroid cysts. Here is a specimen of a large thyroid cyst that had been punctured on many occasions. Not only has hæmorrhage taken place into the interior of the cyst, but the blood has made its way in considerable quantity through the punctures into the cellular tissue of the neck, and there by its pressure caused sloughing of a small part of the skin. In the museum of the Royal College of Surgeons is a specimen (No. 2905) of a large thyroid cyst, the interior of which is full of blood. "During life it was punctured. . . . A considerable quantity of fluid blood flowed from the wound, and the bleeding continued until the patient died."

(2) BLOOD EXTRAVASATIONS may take place into the interior of a soft solid adenoma as well as into cysts as already mentioned. Here is such a specimen of a solid adenoma, in the interior of which is a large blood extravasation.

Extravasations of blood occurring suddenly into the interior of cystic or solid adenomata may cause sudden increase in the size of the tumour and often set up severe dyspnœa. The two following cases, which have come under my own notice, may be cited as



FIG. 4.

Woman aged 33, before and one week after enucleation of a solid adenoma as large as an orange. The tumour was broken up and removed through an incision $2\frac{1}{2}$ inches long. The patient also had wry-neck.



FIG. 5.

examples. A young man was rowing violently on the Thames. Suddenly his neck began to swell, and his breathing at once became so bad that he with difficulty reached the bank of the river. He was found on examination to have a small adenomatous tumour deeply seated in the neck and pressing considerably upon the trachea. He had not previously known of the existence of any swelling. A young woman was laughing heartily, when sudden swelling and dyspnoea occurred in a similar manner. In each case the tumour was removed by enucleation, and found to be a cystic adenoma containing a considerable quantity of blood, the existence of which had been dignosed before operation. Many of the specimens on the table show similar but smaller blood extravasations.

(3) FIBROID DEGENERATION is common in adenomata that have existed for many years and have grown slowly.

Here is a solid adenoma from an elderly person. In the centre you see a large star-shaped mass of dense fibrous tissue. This is a common condition. A more extreme degree in which the whole adenoma is densely fibrous throughout, is rare and seen chiefly in the case of small tumours.

Much more important than this central fibrosis is the fibroid change that takes place at the periphery of adenomata, whether cystic or solid. It may be laid down as a rule that the older an adenoma, the more tough and fibrous is its periphery. This is important in connection with the operation of enucleation. The enucleation of an old adenoma, in which the periphery is tough and fibrous, is much more easily effected than is that of a young and soft adenoma. The latter are less easily distinguished from the surrounding gland tissue, and they are more liable to be torn while they are being separated from the gland in which they lie.

(4) CALCIFICATION is not uncommon in very old adenomata; like the preceding change, it may occur either in the interior of the tumour or at the periphery. It is usually accompanied or preceded by extensive fibrosis. It is of little practical importance.

SYMPTOMS AND DIAGNOSIS.

Many thyroid adenomata cause no symptoms and do no harm. In certain situations, however, and when they have attained a large

size, they may press injuriously upon surrounding parts and cause great trouble.

Pressure is the only serious effect produced by these tumours. This may be exerted (*a*) upon the trachea, causing dyspnœa; (*b*) upon the œsophagus, causing dysphagia; (*c*) rarely upon other structures in the neck, such as the recurrent laryngeal and sympathethetic nerves, veins, &c.

Pressure upon the trachea is, however, by far the most important of these, and the one which most frequently demands active treatment. Severe respiratory trouble is most likely to occur under the following conditions:—

(1) When there are adenomata on both sides of the trachea, which thus becomes compressed between them as they grow larger.

(2) When an adenoma is deeply seated behind the sternum; in such cases it tends to become jammed in the upper opening of the thorax. It may even lie wholly within the thorax.

(3) When the tumour becomes inflamed.

The situation of the adenoma is important in relation to dyspnœa. Prominent adenomata high up in the neck and limited to one side of it never cause serious dyspnœa, unless they are very large and displace the trachea to a very great extent.

An adenoma strictly limited to the isthmus never causes serious dyspnœa, for the simple reason that its pressure is exerted upon the anterior part of the trachea, that is upon the convex part of the cartilaginous tracheal rings, the part best adapted mechanically to resist pressure. It must be remembered, however, that many a thyroid tumour occupying the middle line of the neck and apparently springing from the isthmus, will be found on closer examination to be connected with one or other lateral lobe. Such tumours will displace and compress the trachea laterally and may cause much dyspnœa. If a prominent adenoma is found to be associated with severe dyspnœa, it may safely be assumed either that there is involvement of the lateral lobe at the side of the trachea or that there is a prolongation of the gland extending down behind the sternum. The latter condition is by no means uncommon. It may be the source of much trouble to an operator who unexpectedly finds this condition of affairs in the course of an operation undertaken for what appeared to be a simple and easily removable tumour.

Several photographs illustrating these conditions hang on the wall before you.

When an adenoma is situated in the inferior horn of the gland, that is, at the lowest part of the lateral lobe, it is especially apt to give trouble by becoming jammed in the upper opening of the thorax.

Here is a cast of the neck of a patient with such a tumour, under my care in the Royal Free Hospital. You will see that there is no visible external swelling, and on palpation a mere fulness at the root of the neck was all that could be felt. Here is the solid tumour, nearly as large as a cricket-ball, which, nevertheless, existed in this patient's neck and which was the cause of dyspnœa so severe that it very nearly cost the patient his life. It was drawn up and enucleated, however, and the patient made a rapid and complete recovery.

Dyspnœa coming on quite suddenly or very rapidly with little or no previous warning is usually due either to the tumour becoming thus jammed in the upper opening of the thorax or to its undergoing rapid increase in size, either from hæmorrhage into its interior or from inflammation. Numerous examples of all these conditions have come under my notice in the course of the last fifteen years.

The diagnosis of a single thyroid adenoma is generally easy. A unilateral globular swelling situated in the thyroid gland must be either an adenoma or a cyst (figs. 4 & 6), unless it be due to inflammation or malignant disease. The two latter conditions are, however, comparatively rare, and can generally be distinguished by special characters of their own. A median rounded swelling unaccompanied by any enlargement of the lateral lobes is also either an adenoma or a cyst. It is occasionally difficult to distinguish such a tumour from a parenchymatous goitre, but careful examination of the lateral lobes will almost always prevent any mistake in diagnosis. Lateral deviation of the trachea if it can be detected is especially important since it practically never occurs in purely parenchymatous goitre. When we are dealing with multiple adenomata, and especially with bilateral adenomata, the difficulty in diagnosis is considerably increased. Here, again, the main point in the diagnosis of an encapsuled tumour is the rounded globular nature of the tumour or tumours.



FIG. 6.



FIG. 7.



FIG. 8.

FIGS. 6, 7 & 8.

Woman aged 48. Before, and one week, and one year respectively, after enucleation of a cystic adenoma of the left lobe. There was much tracheal displacement and dyspnoea. Weight of tumour 13 ounces. Anaesthetic, morphia and cocaine only.

The strictly parenchymatous goitre always preserves the general shape of the thyroid gland, and is seldom so lobulated as to simulate a collection of adenomata.

It must be borne in mind that mixed forms are extremely common. A parenchymatous goitre may contain imbedded in its substance one or more adenomata or cysts. Much disproportion between the two sides of a bilateral goitre almost invariably indicates the presence of such a tumour in the larger half.

In the case of an adenoma deeply buried in a large parenchymatous goitre and not easily felt, the diagnosis may often be made quite clear by the internal administration for a few weeks of some

preparation of iodine or of the thyroid gland itself. These drugs, by diminishing the parenchymatous part of the goitre, cause the imbedded tumour to become relatively more prominent, and consequently more easily detected. Such a course of treatment is often an excellent preliminary to an operation for the enucleation of a



FIG. 9.

Showing a transverse scar low down in the neck. One month after enucleation of a left cystic adenoma as large as a duck's egg. It had caused considerable dyspnœa.

thyroid adenoma, causing the tumour to become loosened and more easily removed.

The diagnosis between large adenomata lying in the middle of the front of the neck, and large parenchymatous goitres occasionally presents difficulty to those who are not familiar with the former class of tumour, which is not a very common one.

Here are photographs of three middle-aged women. The three

cases were almost identical (figs. 10 and 11). In each there was a tumour nearly as large as a cocoanut, situated almost symmetrically in the middle line of the neck. In each case the tumour was an encapsuled solid adenoma and was enucleated with the greatest ease. One of these is of especial interest to me since the patient was a lady who had been seen by a well-known physician, and a very distinguished surgeon, both of whom had pronounced the case to be inoperable. The latter had said that if an operation became imperative, "a small piece might be taken away from the centre," a remark clearly intended to denote division of the isthmus of a parenchymatous goitre, an operation wholly inapplicable to a large adenoma. In this particular case the operation was so simple that the time that elapsed between the incision of the skin, and the moment the tumour was on the table, was only $4\frac{1}{2}$ minutes. In a week the patient was perfectly well.

The diagnosis between these large adenomata and parenchymatous goitre can generally be made without difficulty. The diagnosis is made partly by observing carefully the position of the larynx which is almost invariably displaced to one or other side in the case of an adenoma; partly by examining the upper border of the swelling. In the case of an adenoma this is convex: in the case of the parenchymatous goitre there is, of course, a distinct notch between the two lateral lobes.

I may add that in many cases the diagnosis between a solid adenoma and a cyst is, I believe, quite impossible before operation. Very soft adenomata closely resemble cysts, and tense cysts simulate firm, solid, tumours.

TREATMENT.

From what has already been said about the structure of thyroid adenomata it will easily be understood that not much benefit is to be expected from medicinal treatment. Iodine, iodide of potassium, and thyroid extract, so useful in the treatment of the parenchymatous forms of bronchocele, are not of much use when we are dealing with a definite encapsuled tumour of the gland.

The operation of tapping, or of tapping combined with injection, no doubt will cure a certain number of cases in which the adenoma



FIG. 10.



FIG. 11.

Woman aged 38, before, and one week after enucleation of a large solid adenoma which crossed the middle line and simulated a parenchymatous goitre. The dark stain is due to previous painting with iodine.

is soft or contains much fluid. It is, however, a method which is by no means devoid of danger and is very uncertain in its results. In the case of tough, fibrous adenomata and of cysts with thick unyielding walls it is obviously of no use.

The best way of treating most of the adenomata that require any treatment at all is by *intraglandular enucleation*. In this operation, after division of the skin and fasciæ and retraction or division of the infra-hyoid muscles, the thyroid gland itself is incised until the tumour is reached. It is then shelled out with blunt instruments or with the fingers. After all bleeding has been carefully arrested, the wound in the gland is sewn up, the infra-hyoid muscles are replaced and the skin sutured. The wound may or may not require drainage for twenty-four hours.

In the performance of this operation there are three main points which require especial attention.

In the first place it is essential that the strictest asepsis be maintained throughout the operation; this is so obvious that no further comment is needed.

In the second place, the hæmorrhage may be considerable and even dangerous, especially if the tumour be large and solid. The principal part of the hæmorrhage comes from the gland tissue around the tumour; it is best avoided by keeping very close to the tumour itself, where the vessels are least numerous. During the actual enucleation of the tumour from its bed, there may be considerable general oozing which may be impossible to control with forceps. As soon, however, as the tumour has been enucleated, and this can generally be effected in a few seconds, or at the outside in a minute or two, the hæmorrhage can be checked. This can be done either by pressing a sponge into the wound, or by inverting the wound so that its deepest part is brought up to view, the bleeding points being then seen and tied. This inversion can be effected by laying hold of the bottom of the wound with a pair of forceps and drawing it forwards. If this method be adopted care must be taken not to pinch up the recurrent laryngeal nerve.

Another very useful method of inverting the wound is by placing two fingers on the skin at the side of the neck, and then pushing forwards the bottom of the wound from the outside.

Whichever method of stopping hæmorrhage be adopted, the

operator cannot be too careful in seeing that all hæmorrhage is completely stopped before the wound is closed. On one single occasion only have I had to pack the wound with gauze on account of hæmorrhage, and this was in one of my earliest operations, before I had had much practical experience.

The third point to which I wish to draw your attention is the difficulty which sometimes occurs in recognising the tumour. If the layer of gland tissue that covers the tumour be sufficiently thick, there is generally not much difficulty in distinguishing the red gland tissue from the tumour itself, which is usually of a totally different colour, being generally either of a bluish colour or of a yellowish white. If the operator is undecided whether he has reached the tumour or not, it is probable that he has not done so, and that he must cut a little more deeply before he begins to enucleate. In many cases, however, the tumour in its growth has reached the anterior surface of the gland, and its characteristic colour is seen directly the gland is exposed. It is very important, however, to remember that in such cases *there always exists, spread out over the front of the tumour, a thin layer, which is thyroid gland tissue*, although it may be so atrophied by pressure as to be unrecognisable as such to the naked eye. This layer must always be carefully divided before the enucleation of the tumour is begun. If this be not done the operator will find that he is attempting to enucleate the whole lobe of the thyroid and not the tumour only, and his efforts will probably be attended by severe hæmorrhage, to say nothing of other evils.

The difficulty of finding the right plane in which the enucleation is to be effected may be increased in some cases by actual adhesion of the capsule of the gland to the capsule of the tumour, the two appearing to form one single layer. This is especially apt to be the case if the tumour has been the result of inflammation caused by previous tapping. If any difficulty be thus experienced in clearly defining the surface of the tumour, it is best to make the incision, not over the most prominent part of the tumour, but at some other part where the layer of investing gland is thicker and where consequently the difference between gland and tumour is more obvious.

The chief advantages of enucleation over other operations for the removal of thyroid tumour are that: (1) as the operation is conducted mainly within the gland, the cellular tissue of the neck is

not opened up to any great extent; (2) there is no danger of wounding the recurrent laryngeal nerve or other important structures lying in contact with the gland.

None of the thyroid gland itself is removed, and there is consequently no danger of the supervention of myxœdema even if tumours be removed from both sides of the gland.

The chief disadvantage is that the hæmorrhage may be profuse, especially if the tumour be large.

Although enucleation is the operation which in the great majority of cases is most suitable for thyroid adenomata, yet there are cases in which it is better to perform extra capsular extirpation, that is removal, not of the tumour or tumours alone, but of the whole of one lobe of the gland, or even of portions of both lobes. This should be done when, owing to the number of adenomata present, or to the very large size of a single adenoma, it is feared that the hæmorrhage may be very great. In cases, too, in which the diagnosis is very doubtful it may be better to perform extirpation rather than to run the risk of attempting what may prove to be an impossible enucleation.

In performing the operation of *extirpation* a careful dissection is made outside the thyroid gland, and all the main thyroid arteries and veins are isolated and tied before they are divided. There is usually very little hæmorrhage if the operation be conducted carefully and with due attention to the anatomy of the parts concerned. Especial care must be taken not to wound the recurrent laryngeal nerve.

RESULTS OF ENUCLEATION.

On this point we have recently obtained very valuable information from the admirable report "On the Surgical Treatment of Goitre," presented by Dr. J. L. Reverdin, of Geneva, to the French Surgical Congress in October, 1898. Dr. Reverdin collected information from a large number of surgeons in various parts of Europe and elsewhere. Among 1,276 cases of enucleation collected by him there were ten deaths, which gives us a mortality of 0·78 per cent. Of these fatal cases, in seven the cause of death was some affection of the respiratory organs, in three the cause of death was not reported.

My own operations of enucleation of thyroid tumours amount at

the present time (May 28, 1900), to sixty, and among these there has been no death and no serious complication. In a few cases the operation has been followed by a troublesome sinus. It may be remarked that if the operation be not followed by primary union, the resulting sinus is apt to persist for weeks, or even months, as it is difficult to get it to heal.

In my sixty operations primary union has been obtained fifty-five times, the patient having usually been quite well again within a week.

In none of the cases has there been any injury to a vocal cord, and in all cases the dyspnœa or other troubles from which the patients suffered have been completely relieved.

It need scarcely be said that symptoms of myxœdema have never been observed after any of these operations.

LATENT TUBERCULOSIS IN COWS.—The late Sir R. Thorne Thorne in his Harben lectures expressed his opinion that 25 per cent. of the milch cows of this country were actually suffering from tuberculosis. If this be true it is a strong fact in support of the views of those who hold that tuberculosis is often latent, for certainly not 1 per cent. of our milch cows evince any ill-health. The statement is based, of course, on the results of the tuberculosis test. We believe that there has not as yet been obtained any conclusive demonstration of the presence of tubercle bacilli in the milk of tuberculous cows not the subjects of udder disease. Bacilli like those of tubercle have been found in abundance (Prof. J. G. Adami and Martin), but they have not been proved to be capable of conveying the disease by inoculation.

ON THREE CASES OF OCULAR PARALYSIS.

BY C. O. HAWTHORNE, M.D., M.R.C.P.

GENTLEMEN,—The three patients who are here to-day for our discussion have this feature in common, viz., that each is the subject of paralysis of some part of the muscular apparatus of the eyeball. There is also a further similarity between the cases. In each one there is both a paralysis of one of the external muscles that move the globe, and an abnormal condition of some part of the internal muscular function. These conditions are of course interesting and important in themselves, and some of them cause great annoyance to the patients. But their chief importance arises from the fact that such paralyses are very frequently the first evidence of serious organic disease of the central nervous system. Hence, when they occur, it is not sufficient to simply note them, or to be content with a diagnosis which merely records the particular part of the muscular apparatus affected. They claim, on the contrary, a complete and thorough investigation of the patient's history and condition. And necessarily, unless that investigation discovers some sufficient cause for the paralysis, it follows from what I have just said, that the patient almost inevitably comes under grave suspicion of being in an early stage of some serious form of central nervous disease. One cannot, therefore, be too careful in examining these cases, or too guarded in reference to their prognosis. Allowing that there are exceptions, the rule remains true, that an ocular paralysis is a signal of danger. The anxiety is the greater when the patient has reached or passed the stage of middle life; and it is not under these circumstances lessened by the fact that the paralysis is slight in degree or transitory in duration. The very reverse, indeed, is the case. A temporary attack of diplopia, and especially the recurrence of such an event, means very frequently the commencement of locomotor ataxia or some other degenerative process affecting the central nervous system.

These general statements manifestly afford an abundant reason for the careful study of any cases of ocular paralysis that come under our attention. Let us now look at our patients.

First of all, here is a man, aged 45, who has suffered for two years from double vision. Of the immediate cause of that symptom in his case there can be no doubt. His power to move the right eyeball outwards is almost completely gone. He has, in short, paralysis of the right external rectus muscle. To that aspect of the case we will return later. It is well in these cases, I think, to pursue a systematic plan with a view to gain exact information about the condition of each of the various muscular structures. Such an examination is, of course, at once suggested when the patient complains of double vision, and few would omit it in a case of suspected nervous disease. But it might be more generally adopted. The whole examination occupies but a few minutes, and the information gained by it may be of the first importance. There is no reason why it should not be made almost as much a routine proceeding as the examination of the tongue and the pulse prescribed by the traditions of orthodoxy. I, first of all then, examine this man's pupils and note that the two are equal, are if anything rather small, and that each is circular in outline. Then I test the light response, and in doing this I examine each eye separately. The light response, you remember, is a reflex act depending on the completeness of a reflex arc which is constituted by the retina, the fibres in the optic nerve and tract, a centre in the corpora quadrigemina, fibres connecting this centre with the nucleus of the third nerve (Meynert's fibres), fibres in the third nerve, and the circular muscle of the iris. Interrupt this reflex path in any part of its course, and the contraction of the pupil to light will be more or less incomplete. But the reflex path which commences in each retina sends, in consequence of the partial decussation which occurs in the optic commissure, some of its fibres to the centre on the right side of the brain, and some to the centre on the left side. Moreover, the centres of opposite sides are connected by commissural fibres. Hence, a nervous impulse passing from either one or other retina will reach the centres on both sides of the brain, and will lead to the discharge of a motor message along

each third nerve and to the contraction of each pupil. Therefore the contraction of both pupils, when the two eyes are simultaneously exposed to light, though it proves that the efferent (motor) part of each reflex arc is intact, is only a guarantee of the perfection of the efferent (sensory) part of one of the arcs. Given a healthy retina and optic nerve on one side, the other retina or optic nerve may be seriously diseased and yet, if the motor nuclei and nerves are intact, there will on exposure of the sound eye to light be a contraction of both pupils. Hence, in order to secure an accurate conclusion as to the condition of each pupil light reflex, each pupil must be alternately shaded and exposed to light, the other eye during the examination remaining covered. The other condition which must be satisfied, is that during the entire examination the vision must be fixed on some distant object. In near vision there is, of course, convergence of the eye-balls, the innervation of this movement being governed by a special portion of the third cranial nucleus. Together with contraction of the two internal recti there is also, for a well recognised physiological purpose, contraction of the pupil. Therefore, if, in testing the light reflex, the patient is allowed to look at some source of light brought near to his eye, contraction of the pupil is no proof of the integrity of the light-reflex mechanism, for it may merely be the contraction associated with the act of convergence. To eliminate this fallacy, therefore, distant vision must be insisted on, both when the pupil is shaded and when it is exposed to light. Every now and then one sees the state of the pupil tested without observation of either of the above essential conditions. The patient is simply told to look at the other side of the room and then at a bright light brought near to his eyes. Such a method gives quite valueless results. Both pupils under these circumstances may contract, and yet there may be serious disease on one or other side. Or the pupil reflex mechanism may be defective on each side, and the observed contraction be that which accompanies convergence. To avoid these fallacies, therefore, I place the patient opposite to the window, cover over the left eye, and telling him to look at some distant object, shade the right eye with my hand, on removal of which light again falls on the right eye. If the pupil contracts I am sure that such contraction means an un-

interrupted condition of the nervous mechanism governing the movement of the right pupil light-reflex. Similarly I test the left pupil. Now in this man we find that neither pupil reacts to light. There is, therefore, a flaw at some point in the reflex arc on each side. I now test the movement in convergence. First the patient is told to look at a remote object; then holding up my pencil a few inches in front of him I tell him to look at it, and as he does so his pupils contract. The pupils, that is, show the Argyll-Robertson phenomenon, viz., loss of light reflex with persistence of the power of contraction during convergence. This enables us to determine where the reflex arc is interrupted. For it is obvious that, as the pupils contract in convergence, the motor nuclei and motor nerves are intact. Further, as this patient has normal acuity of vision—he reads as you now hear him do the lowest line on the distant test types—he cannot have any serious flaw in the sensory pathway. There is only one part of the reflex arc remaining, viz., the fibres which join the centre in the corpora quadrigemina to the third nerve nucleus. An interruption in Meynert's fibres would, you see, constitute a breach of the reflex apparatus. It would, as it were, detach the afferent and efferent portions of the arc, without injuring the one or the other. Consequently, when the centre for convergence is active, it has an uninjured motor pathway along which it can discharge a message to cause contraction of the pupils; and similarly, the sensory pathway being unbroken, nervous impressions can pass along it to the true visual centres in the cerebral hemispheres, and the patient's power of vision remains undisturbed. But the light reflex is lost because the impression excited in the optic nerve and tract by the action of light, though it reaches the corpora quadrigemina, cannot pass thence to the motor nucleus of the third nerve. The connecting fibres between the two are broken. That is the meaning of the Argyll-Robertson pupil. Our patient, therefore, has a lesion, probably an area of sclerosis, in the region indicated. We now test his power of accommodation. As we have already seen, he has normal distant vision—he is practically emmetropic. Now I give to him the near types, and as you hear he reads, with each eye, the smallest size at twelve inches distance. To do so he must have the power of accommodation, that is to say, his ciliary muscle.

acts vigorously and well. As he is 44 years of age he has entered the presbyopic area, and might well have been unable to read the smallest type without the assistance of a weak convex lens. If he had needed a + 1 D in order to be able to do so we should still have been justified in concluding that his accommodative power for his age was perfectly normal. In this respect he is, if anything, rather above than below the standard. In regard to the external muscles we have no need to apply elaborate tests. It is written so plainly that even he who runs may read the almost complete paralysis of the right external rectus, which of course means a lesion of the nucleus or fibres of the sixth nerve. Now, I must ask you to take it from me that the Argyll-Robertson phenomenon and the sixth nerve paralysis are the only evidences of nervous disease which the man presents. You must also please accept my statement that the physical examination of the chest and abdomen is strictly normal, and that the urine is free from albumen and from sugar. This last statement is the more important as an ocular paralysis sometimes occurs in the course of diabetes, presumably from peripheral neuritis. Cases are also reported in association with Bright's disease. But we have neither of these conditions here. Nor have we anything in the man's history to justify us in regarding the ocular palsy as "rheumatic," a term sometimes applied—I am not prepared to say incorrectly—to cases for which we can find no adequate explanation. And, further, neither rheumatism, glycosuria, nor albuminuria will account for the Argyll-Robertson pupil. On the other hand, we know that the patient some nine years ago had a sore on his lip followed by "blood-poisoning." The existence of an ocular paralysis, unless some other adequate explanation can be found, must always give rise to a suspicion of syphilis. The Argyll-Robertson pupil points perhaps still more strongly in the same direction. When, as here, we have the two events associated and, in addition, such a history as I have just related to you, no reasonable doubt can exist that the patient is the subject of pathological processes in his nervous system due directly or indirectly to syphilis.

Now we will look at our second patient. He is a man of 47, and like No. 1, he complains of diplopia, but without any manifest ocular palsy. Examination reveals that he also exhibits the Argyll-

Robertson pupil. His visual acuity is good, and his power of accommodation is fully up to the standard normal for his age, that is he reads with a + 1.0 D lens the smallest type at twelve inches. But though he complains of diplopia, his ocular movements seem to be fairly satisfactory. A complaint of diplopia must, however, never be dismissed on the ground that by the direct observation of the physician no ocular paresis can be detected. A very slight defect in the muscular co-ordination is quite sufficient to bring the retinal images on to parts of the retina not in absolute physiological correspondence, and thus to produce double vision. In the earliest stage of an ocular paralysis, and also when a paralysis has nearly disappeared, patients frequently experience double vision, though to ordinary observation the ocular movements seem quite satisfactory. The lesson, of course, is never to deal lightly with a complaint of double vision advanced by a patient, even though he seems to move his eyeballs freely in every direction. There is one practical point of observation in this class of cases which is worth noting, and it is illustrated in our present patient. You may fail to detect any defective movement on either side, and yet if you look carefully you may notice that in one position or the other the movement of the globe—it is the unaffected one—seems to be excessive, the so-called “secondary deviation.” Observe when this man looks to the extreme left. The excursion outwards of the left globe appears to be complete. At the same time the right globe is rotated inwards to an excessive extent, so that there is not strict parallelism of the visual axes. It is as if the patient were able by discharging an unusually powerful stimulus to get a normal degree of activity in the damaged nervo-muscular mechanism which carries the left eyeball outwards. But such a degree of stimulation causes excessive activity of the healthy nervo-muscular mechanism which performs the associated movement of the right eye, and this globe is therefore rotated inwards to an abnormal degree. Hence, when observing the movements of the eyeballs in a case of diplopia, you must be on the look out for excessive, as well as for defective movement. But we can go further than this. I make this man hold a red coloured glass in front of one of his eyes, and then place a lighted candle two to three yards in front of him. If his visual axes are not strictly parallel, images will be formed on different

parts of the two retinae, and as he will see the images of different colours he will more readily appreciate the existence of the two. Maddox's rod, which I show to you, may be used for the same purpose. It is a solid glass cylinder, which, when looked through, gives to the flame the appearance of an elongated vertical bar of light. If the two globes act perfectly together this bar of light and the flame of the candle will correspond in position. If not, the two will be separated by an interval of greater or less extent. We test our patient by means of the coloured glass and find he sees two images, which he calls a red and a white candle. He undoubtedly has diplopia. He is holding the coloured glass in front of his left eye, and I ask him whether the red flame is to his right hand or to his left. He replies to his left. The diplopia therefore is *homonymous*. Had the red flame been to the patient's right hand, the red glass being still in front of the left eye, the diplopia would have been *crossed*. In every case of diplopia, after verification of the existence of the symptom, the next point to determine is whether it is *homonymous* or *crossed*. For homonymous diplopia always means a paresis of the muscular apparatus that carries the eyeball outwards, and crossed diplopia a defect in the muscular apparatus that moves the eyeball inwards. The reason for this is shown in the diagram which I now point to. Say the left external rectus is more or less completely paralysed. The unopposed internal rectus will rotate the globe a little inwards, even when the patient is looking straight to the front. Consequently the image in the left eye will be formed, not on the yellow spot, but a little to the inner (nasal) side of the yellow spot. But images formed on the inner (nasal) half of the retina are referred to the outer (temporal) half of the visual field. That is, in the case supposed, viz., paralysis of an external rectus muscle, the image formed on the retina of the affected eye will be referred to the same side of the patient. The diplopia will be homonymous. The same principle explains the fact that in paralysis of a muscle that moves the eyeball inwards, the diplopia is crossed. The image in the affected eye will be formed to the outer (temporal) side of the yellow spot, and will be referred to the inner (nasal) side of the visual field, that is to the side of the visual field, opposite to the side of the affected eye.

In our present patient, then, the diplopia is homonymous, and we

know, therefore, that there is a defect of the muscular power which under normal circumstances moves one of the eyeballs outwards. The next step in the diagnosis is the determination of the question whether the right or left eye is at fault. That is easily settled, for it is obvious that the diplopia must be most marked when the patient is called upon to place the eyes in a position which can only be attained by a complete contraction of the paretic muscle. I, therefore, move the candle first to the extreme right of the patient, then to the extreme left. In the present case I find that when the flame is on his extreme right the two images are fused, that is there is no diplopia. The muscles which secure this position therefore act satisfactorily. On the other hand, as I carry the flame to the left, the diplopia becomes more and more extreme, the distance between the images becoming greater and greater. The fact that the diplopia is homonymous teaches us that there is a defect of the muscles turning one of the eyeballs outward, and the fact that the diplopia increases towards the patient's left shows us that the muscular apparatus affected is that of the left eye, for the diplopia always increases in the direction of the action of the paralysed muscle. Now, whilst the main muscle turning the eyeball outwards is the external rectus, the superior and inferior oblique have also some action in that direction. But, of course, besides their outward turning power, these muscles rotate the globe, the former downwards, the latter upwards. Hence if the superior oblique is paralysed, say on the left side, there will not only be homonymous diplopia increasing to the left, but as the left eye cannot be carried fully downwards, the image of the lighted candle, when this is carried into the lower part of the field, will be formed, not on, but above the yellow spot, and will be projected to a lower level than the image focussed on the right yellow spot. Similarly, when the inferior oblique is paralysed, the eye cannot be properly rotated upwards, and therefore the diplopia will increase when the patient is made to look upwards. I, therefore, carry the candle first towards the floor and then upwards above the patient's head, and in both of these positions he tells us that the two images are on the same level. Therefore, there is no defect in the muscles which move the eyes upwards and downwards respectively. The paralysis we conclude, is limited to the external rectus.

Thus by different stages we have established (1) that diplopia exists; (2) that as it is homonymous it is due to defect of the outward turning mechanism; (3) that as it increases to the left side, the left muscular mechanism is the one at fault, and (4) that as there is no inequality of level in the images in either the upper or lower parts of the field, the paralysed muscle is one which has purely an outward turning action, viz., the external rectus. The second patient has, therefore, like the first, not only the Argyll-Robertson pupil, but also a paresis of one of the external recti. In the first patient the right muscle was very obviously paralysed; in the second the left muscle is affected, and the recognition of the flaw can only be confidently attained by the use of a special method of testing.

The third patient is a man of 35 years. He complains that six months ago his ability to read small print began to fail and has now quite disappeared. More recently he has experienced double vision. Examination shows each pupil widely dilated and immobile, both under the influence of light and in the act of convergence. There is *iridoplegia*, or paralysis of each sphincter pupillæ. Now we test his accommodative power. With the right eye he reads the distant types perfectly—his visual acuity is up to the normal level; but when I give him the near types and ask him to read we find that he is quite unable to read the small print, marked J 1. The smallest type he can read are those letters of considerable size marked J 20. His right eye is emmetropic, and, as we should expect from the fact that his distant vision is normal, the refractive media are clear and the fundus oculi appears to be healthy. But he is unable to focus on his retina the strongly diverging rays which enter the eye from near objects. At his time of life he ought to be able to do this with great ease. His ciliary muscle ought to be sufficiently powerful and his lens sufficiently elastic. But, if his ciliary muscle is paralysed, he cannot, of course, throw it into contraction, and consequently cannot bring about that greater degree of convexity of the anterior surface of the lens which is necessary to focus on the retina the strongly diverging rays which enter the eye from near objects. His failure to read the small type, when we know his capacity for distant vision is normal, shows this to be the case. The demonstration can be made even more complete, for I now

make him look at the near types through a moderately powerful convex lens (+ 4.0 D), and he at once reads the very finest type. The convex lens I have placed in front of his eye takes the place of his increased convexity which he ought to be, but is not, able to impart to the anterior surface of the crystalline lens in the act of near vision. The state of matters in left eye is practically the same. There is, therefore, on each side not only *iridoplegia* but also *cycloplegia*, or paralysis of the ciliary muscle. This is a condition which is met with every now and then as one of the forms of post-diphtheritic paralysis, and it may occur without any paralysis of the soft palate or of the limbs. The knee-jerks may be lost or may remain in a normal condition, and there may or may not be *iridoplegia*. The child complains of inability to read and yet is quite able to read when made to look through a convex lens. These cases not infrequently follow slight attacks of diphtheria—attacks which are often regarded as some simple form of sore throat. Fortunately, under rest, perhaps aided to some extent by tonics, the patient almost invariably recovers in the course of a few weeks. In our present patient we cannot accept a suggestion that the paralysis of his pupils and ciliary muscles is a post-diphtheritic event. Apart from other considerations the duration (six months) is decidedly against such a diagnosis. Neither he himself nor any member of his household has suffered from diphtheria or “sore throat.” Then he has also diplopia from, as we shall see, paralysis of some part of the external muscular apparatus, and though this is not impossible from diphtheria, it is a comparatively rare consequence of that disease. Let us now test the action of the external ocular muscles by our former plan. We place the coloured glass in front of his left eye, and he says he sees two candles, the red one being to his right side. He has, therefore, *crossed* diplopia. This, we know, means a defect of some part of the inward turning muscular mechanism. I carry the candle to the right and the two flames approach one another. Therefore the inward turning mechanism of the left eye acts well. Now I move the candle to the patient’s left, and the gap between the two flames gets wider and wider, therefore the defect is in the muscles which move the eyes to the left. The diplopia being of the crossed variety we know it is not the external turning muscles of the left that are

at fault. We have, in short, localised the flaw in the muscles which turn the right eyeball inwards. The most important of these is, of course, the internal rectus, but the superior and inferior rectus also have some power in this direction. They, however, like the oblique, rotate the globe upwards and downwards respectively. But as in the present case the level of the two images remains the same both when the candle is raised to a height and when it is carried downwards, we know there is no defect in the power to rotate the eyeballs either upwards or downwards. Therefore the defect—it is not here a very marked defect—is in the internal rectus muscle of the right eyeball. The stages by which we have arrived at this result are those you always have to pursue in attempting to localise an ocular paralysis. First of all, find out whether there is diplopia, testing for this in all possible positions of the eyeballs. Secondly, you determine whether the diplopia is *homonymous* or *crossed*. The former means defect of outward turning muscles, the latter of inward turning muscles. Then, by noting in which direction the diplopia increases, you conclude on which side the paralysis lies, remembering that, as is to be expected, the diplopia always increases in the direction of the action of the paralysed muscle. So long as the paralysis is, as in these three cases, confined to muscles the action of which is simple, moving the eyeball directly outwards or directly inwards, the identification of the defect is a comparatively easy matter. It is different when the superior or inferior recti or the oblique muscles are involved. Each of these not only rotates the globe either upwards or downwards, and also to some extent outwards or inwards, but further, each inclines, in one direction or the other, the vertical axis of the cornea. Consequently in paresis of any of these there is not only displacement of the image to the right or left, but also displacement upwards or downwards in the upper or lower part of the visual field, and in addition, the image seen by the affected eye will be sloped away from the vertical in consequence of a want of parallelism between the vertical axes of the cornea. The diagnosis thus becomes more complicated. It is, however, a not inconsiderable step towards a precise diagnosis to remember the three general statements—that a paralysis of an outward turning muscle causes homonymous diplopia, and of an inward turning muscle

crossed diplopia ; that the outward turning muscles are the external rectus and the superior and inferior oblique, and the inward turning the internal rectus, and the superior and inferior recti ; and that the degree of diplopia becomes most marked in the direction towards which it is the function of the affected muscle to act. Beyond this point the greatest assistance is found by recalling Dr. Louis Werner's diagrams, which I show you here, and which you will find in some of the ophthalmic text-books. They show most simply and ingeniously the exact character of the diplopia produced by a defect in each of the superior and inferior recti and oblique muscles.

Regarding now the complete diagnosis in each of these three patients, I must be content with a few very general statements. No one of them gives, even to repeated examinations, any evidence of organic disease other than those we have discovered in testing the functions of the ocular muscles. Yet there can be no reasonable doubt that in each patient there are organic changes in the central nervous system, which may, and probably will, sooner or later extend and produce further symptoms. The first patient has certainly had syphilis ; the second some years ago had a venereal sore, not, as far as he knows, followed by any secondary symptoms ; the third denies any form of venereal disease. In none of them is there any evidence of disease of the spinal cord, yet in the first two, at all events, the probability of the appearance sooner or later of the spinal symptoms of locomotor ataxia is considerable. Just as this disease may commence with optic atrophy, it may commence with paralysis of an extra-ocular muscle, or possibly with the Argyll-Robertson pupil, and the interval between any such event and the spinal evidence may be very long or very brief. I think each of these two patients lies under the suspicion of such a development. The third patient must also be regarded as the subject of a chronic degenerative process in the central nervous system, and therefore to demand a very guarded prognosis. The prospect of relief from his present symptoms is, I fear, a very poor one. On the other hand, he may remain without further development for an indefinite time. I have seen several patients, each of whom has remained with iridoplegia, cycloplegia and diplopia in various degrees for some years without any evolution of further symptoms, and one man in whom irido-

plegia developed nearly five years ago, and who, but for this defect, remains to-day in perfect health. As far as treatment is concerned, my own disposition is, if one sees the patient soon after these ocular paralyses appear, to bring him promptly and thoroughly under the influence of mercury given by inunction, and to order potassium iodide by the mouth. This is adopted in view of the paralysis depending on a syphilitic meningitis. If the paresis has been in existence for some time—weeks or months—the chance of removing it is very slight, and, if mercury does not rapidly succeed, the patient had better get a course of nerve tonics, such as arsenic, strychnine, &c.

These, however, are merely general statements. My main purpose in placing these three patients before you is to demonstrate the method in which paralyses of the several parts of the muscular apparatus of the eye-ball can be recognised, and to emphasise the importance of such paralyses as frequently being early events in the development of chronic disease of the central nervous system.

MR. BURDETT COUTTS AND THE BLOEMFONTEIN HOSPITALS.—All who contain exaggeration, even in a good cause, must have felt thankful to Mr. Watson Cheyne for his clear and candid description of the real state of things at Bloemfontein. Mr. Cheyne was there during the period to which Mr. Burdett Coutts's sensational letter referred. It has been claimed by some that he corroborates the statements of that letter, and to some extent such a view of the matter is correct. In the main, however, it is far from being so. Mr. Cheyne very clearly implies that Mr. Burdett Coutts has described as if lasting and almost characteristic, conditions and occurrences which were very transitory and exceptional. There is a very large difference in the impressions which the two narratives leave on the mind. Mr. Cheyne attributes the temporary inadequacy of supplies and accommodation to their true cause—the interrupted railway communication.

ON INFECTIVE ANGEIOMA IN ASSOCIATION WITH TUBERCULOSIS.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

AMONGST the examples of very rare diseases which we had before us on April 11 was a young Jew girl, sent to us from one of the mission hospitals, who had a large angeiomatous tumour on one knee. Part of the tumour was subcutaneous and consisted of a soft puffy swelling with ill-defined boundaries, of which nothing revealed the existence except the altered contour of the limb. The skin overlying these was quite healthy. Near to them, however, and exactly over the patella, there was a large patch of cutaneous nævus, almost black in colour and looking like a flattened congeries of small black currants. Above and below this large patch were several smaller ones—satellites—some of deep red colour and others almost black. These have slowly increased of late; indeed, some of them are new developments, but the parent nævus was present at birth. We have, then, proof that the condition is locally infective; the patch is spreading, and it is causing others to be developed in its proximity. This is not what is usual with congenital nævi. I must direct attention also to another, namely, that the dilated blood-vessels could not be emptied of their blood; no amount of pressure could alter their colour; yet the blood in them was not extravasated, nor was it in a state of common thrombosis, for it underwent no change whatever from month to month.

The features noted in this case were, as I remarked, those which are now well recognised as characteristic of what we know as infective angeiomata. Very often the vascular changes are attended by the formation of lymph vesicles also, and we have a mixed condition of lymphangioma. What is the nature of the infective element? I have ventured the suggestion that it may possibly be tubercular, and that the process should rank as a form of lupus. It may spread extensively, but it usually remains local like lupus vulgaris.

Our patient is a girl of 14, well grown, and exceedingly florid.

She has a patch of lupus vulgaris on her right forearm which has been slowly spreading for two years, and she has many ulcerated chilblains on her hands which can scarcely be distinguished from spots of iupus. Her hands, like her cheeks, are very red. We have her assurance that her hands get well in summer, otherwise I should be inclined to suspect that some of the sores were in the early stage of lupus. One of her fingers is swollen, and there is a long scar down its palmar aspect, the result, we are told, of an incision for a scraping operation for the cure of a scrofulous abscess some years ago. This conjunction of lupus with ulcerated chilblains is not a rare occurrence, and the character of the chilblains may vary very much, as also may the nature of lupus, for we sometimes meet with them in association with lupus vulgaris and sometimes with lupus erythematosus. It is clear that the state of nutrition which favours the development of chilblains favours also scrofulous or tuberculous affections, of which lupus is one. Many chilblains are not improbably of tuberculous origin.

Now let us ask as to our patient's family history. She has herself, with the exception of the local ailments which we have looked at, had good health, and she looks at least two years in advance of her age. She has an excellent set of white teeth. Her mother, who comes with her, is delicate looking, and has scars in her neck, the results of the excision of glands in early life. She tells me that she was at one time much out of health, had cough and spat blood, and that Dr. Sydney Ringer told her that she had "lung disease." Two others of her children have shown scrofulous manifestations and one has had diseased bone. Thus we find that a mother and three of her children are, or have been, scrofulous (*i.e.*, tuberculous). How are we to understand these facts? Are we to suppose that each individual has been separately inoculated with the tubercle bacillus, or has received it in air or food? According to such a theory we might believe that what had passed in inheritance from mother to children had been solely a state of tissues, and perhaps of circulation, likely to favour the attacks of the bacillus. I am myself, however, inclined to go much further than this. I am a believer in the possible latency of the tubercle-bacillus for quite indefinite periods, and in its existence in, and quiet symbiotic union with, the tissues of very many in which it is not suspected. I hold that in

this form it may pass with sperm or germ from parent to offspring, and may remain in the latter ready under favouring circumstances to manifest activity. Perhaps it is present in almost all of us.

The infective angioma which our case illustrates is a local disease; I have never seen it symmetrical, that is, bilateral. The treatment to be adopted is that for lupus, that is, the destruction by cauterisation or other means of the diseased and infective portions of tissue.

My case is not the first which has been recorded in which infective angioma has been met with in association with ordinary lupus. Long ago I ventured to name certain forms of lymph-angioma "Lupus lymphaticus," and such cases as the above give a certain amount of support to the creed implied in that name. More, I do not doubt, will in the future be forthcoming.

THE FOSTER-WYNDHAM LETTERS.—It is, we think, much to be regretted that the letters which passed between Sir Walter Foster and Mr. Wyndham have been supplied to the newspapers. Their publication at the present juncture can serve only the purposes of party politics. It is not difficult to understand the temptation, but it ought to have been resisted. Sir Walter's offer was a patriotic one, but it does not follow that Lord Lansdowne was not very wise in declining it, nor that, if it had been accepted, things might not have been yet worse. No one who knows Sir Walter doubts his sagacity or his capacity for organisation, but there may still be scepticism as to how far a divided responsibility between him and the Army Medical Staff would have been a success. Lord Lansdowne was quite right in the distinction he drew between civil surgeons at the seat of war and civil physicians. There is an obvious vocation for the former, and there should be little or none for the latter. If an experienced army medical officer is not more likely than a civilian to know how to provide for the sick in field and base hospitals he is not fit for his post. Knowledge in such matters is of the very essence of his life's duty. On the other hand opportunities for acquiring dexterity in operating are not possible to the military surgeon in time of peace.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY DR. WILLIAM EWART.

V.—*Sketch of an Ideal Medical Treatment of Empyema.*

THE case of the young boy now before you is one of those in which a first aspiration draws serous fluid and is followed by the formation of pus. For the relief of the latter a piece of rib was excised six months ago and the abscess drained in the usual way. He spent nearly four months at our convalescent hospital at Wimbledon, but on his return his sinus was still discharging and his left chest was collapsed and did not expand. Before submitting him to further surgery I determined to try the effect of systematic respiratory exercises, which I will presently explain; and the result has been satisfactory so far, both as regards the sinus, which is now shorter, and the expansion of chest, which is greatly improved.

I may now venture, from a medical standpoint, to give you a sketch of what I would consider to be the ideal treatment of empyema, though this, like many ideals, may not be always attainable.

(1) An early operation, *without resection of ribs*.

(2) An incision between the ribs of sufficient length to provide for the ready escape of purulent shreds, &c.; this should be kept from uniting at its two ends by a piece of gauze, or by some other suitable plug (perhaps of india-rubber), which might be made to increase the distance between the two ribs.

(3) The complication of a drainage-tube should be avoided if possible, though there would be less objection to a short, flat, broad tube just long enough to reach through the parietes without projecting into the pleura, and provided with a flange capable of intimate and secure adaptation to the skin. The self-retaining short tube, with internal as well as with external flange, is an appliance which still remains to be constructed on a practical pattern.

(4) Emptying the chest is to be promoted *passively* by gravitation and *actively* by respiration; that is in the ordinary bed by

alternating the right and the left decubitus, and by the early adoption of respiratory exercises out of bed.

(5) The ordinary *garden-hammock* is a device by which I am now seeking to combine both indications. The patient is made to lie on his damaged side, not in the middle of the hammock, but well towards the foot end, so that the legs rise sharply towards the supporting cords. The result is that the lower part of the trunk and pelvis are raised, and that the hollow of the hammock is occupied by the thorax. A small pillow is placed under the head, but the shoulder, as well as the side of the chest, must be allowed to sink. If this posture be arranged successfully, the sound side, which is uppermost, will be bent in and hampered in its respiratory movements, the damaged side will be made convex and will be found to be breathing actively, whilst the escape of pus is favoured both by gravitation and by the wound being kept open by the increased distance between the ribs. I am unable at this early stage to give any statement of results, but the patient is carrying out the hammock treatment without any inconvenience or discomfort.¹ I hope that the same principle may be also found applicable at an early stage after operation, and that it may help to obviate the chronic condition which is presented by this patient.

(6) The chest is to be exercised by sitting out of bed, walking, &c., as soon as the immediate shock of the operation is recovered from, that is, in a day or two, provided that there is no contra-indication, and the respiratory exercises are to be gradually and systematically increased.

(7) *The respiratory exercises*.—"No resection" was suggested with a special view to thoracic integrity, without which these exercises can hardly be begun early. Various exercises have been devised, and they are all good if their effect is to produce expansion. There are two methods for expanding the lung: (1) the *passive, internal, expiratory, or atmospheric-pressure method*, and (2) the *active, external, inspiratory, or thoracic-expansion method*. To the first belong all plans which increase the pressure in the trachea, and therefore in both bronchi; they are modifications of common expiratory straining. For instance, the patient is made to go through a

¹ Since the above was written good results have been obtained from the treatment.

silent handkerchief performance. The nose is to be held completely, instead of partly, closed, and the mouth is also tightly closed during the effort of blowing the nose. This performance can be repeated at frequent intervals during the day. An excellent device, which we owe to Dr. Ralston James, is that of blowing a quantity of water to and fro through two large Woolff's bottles. When one bottle is filled the operation is reversed and the water driven back into the other by the breath. This means that increased pressure is set up in the air-tubes of the unexpanded lung as well as in the bottle.

This boy is an adept in the "active respiratory method" which he has come here to show you. He has practised it most diligently a few minutes every hour from the time when I explained it to him, with the result that the left chest at once began to expand and has done so increasingly since. The method can be carried out in the standing or in the sitting position. When the patient is standing, the feet are slightly separated, the knees kept rigid if possible, and the hand and shoulder corresponding to the sound side of the chest are dropped till the hand can grasp the ankle, or even the under surface of the arch of the foot. The bending should not be forwards, but as strictly lateral as possible, with the eyes directed to the ceiling. This position absolutely paralyses the ribs on that side and doubles the thorax upon the side of the abdomen, stopping any downward movement of the diaphragm and of the lung. Whilst the patient is in that position he is made to breathe freely and deeply, and the collapsed chest is compelled to move and the lung to expand. You will observe that in our patient the left border of the chest is rendered convex, and that the ribs are separated or tend to separate. The patient will tell you that this enables him to expel with each cough some of the pus when there is any to expel. Perseverance with this method will, I hope, gradually fill up the chest with expanded lung and gradually heal the empyema without any operation, particularly if he can be so fortunate as to gain admission at the Margate Sea Bathing Infirmary.

I should be grateful to any who would criticise, aid, or improve these mere physician's suggestions.¹

A few points referred to in these notes were not mentioned at the consultations.—W. E.

REVIEWS AND NOTICES OF BOOKS.

- I.—THE CAPE OF GOOD HOPE LEPROSY COMMISSION, 1894. *Minutes of Evidence*, vol. i., a Blue Book, pp. 601. Cape Town.
- II.—THE SAME. INTERIM REPORT OF COMMISSIONERS. *Minutes of Proceedings and Appendix*, vol. ii.
- III.—THE SAME. *Abstract of Replies to Interrogations; Correspondence; Acts relating to Leprosy, &c.*, vol. iii.
- IV.—THE SAME. FINAL REPORT OF COMMISSION. *Minutes of Proceedings and Appendix*, vol. iv.

(Continued from page 55.)

LEPROSY BEGINNING DE NOVO IN NATAL.

As regards Natal, the most important evidence was that given by Sir Theophilus Shepstone. He stated that he had been intimately acquainted with the native population for thirty-one years.

“Q.—Did you know that leprosy existed among them?

“A.—I knew that it existed in one tribe only—the Amapeteta.

“Q.—Can you tell the Commission when the disease first showed itself in that tribe?

“A.—The people themselves say that its first appearance was after 1843, and the first death from it, that of the chief's eldest son, Bafakee, occurred after my arrival in the Colony in 1846, since which it has spread slowly but surely among the tribe and was for many years looked upon by the natives as a local and tribal affliction, the introduction of which they attributed to witchcraft.

“Q.—Has it since spread from the Amapeteta tribe, and by what means?

“A.—For many years it was not known to have spread to any other tribe, and it is only within the last ten or fifteen years that I know of its having done so. I find, however, that it has established itself in a good many localities, some near and others at a long distance from the tribe where it first broke out. As regards those cases in the nearer neighbourhood of the first infected tribe, the natives profess to be able, and apparently with good grounds, to trace the breaking-out of the disease to inter-marriage or personal contact. The details of some of the cases described by them are, however, so contradictory, that nothing except a most searching enquiry by the Commission into every typical case will, I think, render it possible to adopt any practical theory on the subject.”

Sir Theophilus insisted on the importance of such an enquiry, and speaks of "the rapid strides" which the disease is making. Now two points are made tolerably certain by his evidence. First, that the disease is of recent introduction (or origination) in Natal, and next, that it has sprung up as if, *de novo*, in many parts at considerable distances from each other. No suspicion is hinted that it was introduced to the Amapeteta tribe from without, and although the disease is new in Natal since European occupation, there is no suggestion that any Europeans have suffered. It would appear to have begun amongst the natives and to be confined to them. We have no hint of the Chinaman or the Coolie, who in so many places is credited with the introduction of the disease. The Amapeteta tribe are, of course, Kafirs, and it is reported that the Kafirs will not eat fish. If, however, it should turn out that they will eat salted fish, and that about the date given this article of food became accessible to them, a very valuable item of evidence will have been obtained.

In the "Report of the Natal Commission on Leprosy" (1885) it is expressly stated that at the time when leprosy first showed itself in the Amapeteta tribe there had been no possibility of introduction of the disease by immigrants.

EXTRACT FROM THE REPORT OF THE COMMISSION ON LEPROSY IN
NATAL, 1885.

"It appears impossible that leprosy in this Colony should arise from causes assigned for its appearance elsewhere, such as bad sanitation, diet of salt meat, salt fish and vegetables in an unwholesome state, none of these causes being applicable to natives in this Colony. Their dwellings are airy, constructed of basketwork, so to say, and covered with grass, through which the air penetrates. The insides of the huts are kept scrupulously clean, and the kraal (a collection of huts) also, in fact a native dwelling will compare favourably with an ordinary labourer's cottage in Great Britain or Ireland. The situations selected for the erection of kraals are dry, airy, and elevated. The people do not eat fish—fresh, salt, or putrid. The little meat they do eat is, as a rule, anything but putrid. They use Indian corn where Europeans use wheat; the grain is as good in

one case as the other. Leprosy cannot therefore be traced to any of the above-mentioned causes."

A source of fallacy possibly exists here in the fact that during the Dutch occupation of Natal Hottentot slaves were forced over the frontier in order to serve as shepherds, &c. The native Kafir male population had been to a large extent killed off in the wars, and Dutch habits were extensively introduced, together with Dutch slaves and probably Dutch food.

It will be seen that the facts as regards this outbreak are equally unexplained by the suggestion of contagion and by fish food. The strong assertion is that no possible source of contagion could be traced. Nor did the mode of spreading favour the idea of contagion. The disease did not prevail largely at any one spot, but occurred to a few individuals here and there.

(To be concluded.)

MUSEUM NOTES.

THE following descriptions of the principal insects, which, in England, attack the human skin, are from the pen of the late Mr. Tuffen West, F.L.S. The original very beautiful drawings to which they refer have just been added to the Museum. Most of them were executed by Mr. West from nature, and on this account, as well as for the minute accuracy for which Mr. West's pencil was famed, they have a high value. Most of them were figured in the catalogue of the "New Sydenham Society's Atlas of Skin Diseases," but our Museum now possesses the original drawings.

DERMANYSSUS GALLINÆ (♂ ?), AND DEVELOPMENT.

Fig. 1 represents the under surface of a supposed male *Dermanyssus gallinæ*; *md.*, mandibles; *lb.*, labium; *lbp.*, labial palp.; *st.*, sternal portion of the thorax; *vs.*, ventral shield, with the opening of the vent, *v*, much resembling the stomatal cells of plants. There are two minute tactile setæ on this shield, *sp.*, *sp.*, spiracles, equivalent to the meta-thoracic spiracles of insects; in some *Acar*i there is another pair of spiracles present at the base of the anterior pair of limbs. I think there is here a very minute pair at that place, but that it would require the examination of

fresh specimens to feel certain about it. The figures are put to the several pieces composing the limb, which is terminated by a fan-shaped acetabulum.

Fig. 2.—Egg of *D. gallinæ*, found on a feather from the fowl-house of this woman.

Figs. 3, 4, 5 represent other eggs of the same, in different stages of development, from the same place.

Fig. 6.—A young specimen, just hatched out.

Fig. 7.—Another egg of *D. gallinæ*, in empty ova-case of *Pediculus vestimenti*; showing "yelk-segmentation" well. This specimen was found on the shawl of the woman. It is figured, with remarks, on another plate, "*Ova-cases of P. vestimenti*."

DERMANYSSUS GALLINÆ, ♀.

A female of *Dermanyssus gallinæ*. This specimen was taken, with others, from a woman who applied at the Hospital for Skin Diseases for irritation caused by these mites.

Dermanyssus is a genus of the order *Acarina*, in the family *Gamasea*.

The characters are: "Body mostly soft; palpi, the fifth (last) joint smallest labium acute, mandibles of the male chelate, external claw very long; of the female, ensiform; anterior legs longest, coxæ approximate ("Micr. Dict.," 1860, p. 212.)

One species is very troublesome occasionally to those who keep canaries and other cage birds—this is *D. Avium*.

In Küchenmeister ("Manual of Parasites," vol. ii., pp. 62-65), will be found some interesting notes on cases similar to that which furnished the present example.

And in Gamgee (iii., 217) is reproduced from the *Veterinarian* a remarkable case of "Poultry Lousiness in the Horse," which affected a stable of eight of these animals and which was traced to over proximity of a hen-house.

I have good specimens of this mite, obtained under the following circumstances: In the early summer of 1868 a friend residing at a farm-house at Haslemere had a cart-shed cleared out as a play-place for his children in wet weather. On the beams supporting the roof of this shed fowls had for long been accustomed to roost, and it should be stated also that the roof was of thatch. When the children began to use this play-place, and for some time after, they were very much annoyed by the irritation of pimples about the neck and shoulders, apparently produced by the bite of insects. Visiting the place in July of that year, I found the beams swarming with these *Acarî*, and secured a number. I have also, on two occasions, had them troublesome to my fowls (May, 1875).

DERMATODECTES OVIS, ♀.

A female of *Dermatodectes ovis* (Gerlach). The last pair of limbs here is terminated by setæ, as in the females of others of these skin *Acarî*, wherever certainly known.

See the figures of female of *Sarcoptes hominis* and *Dermatodectes bovis*, of this set; of *Sarcoptes equi* (Gerlach) in Gamgee ("Dom. An. in Health and D.," iii., 165), *S. seris* (175), and *S. canis* (176) of the same work. Not having yet obtained access to Gerlach's original work I am here, for the present, obliged to make my references to his reproducer. The figure of *Sarcoptes cati* (p. 177) has acetabula on the last pair of limbs, and is correctly given as that of a male.

DERMATODECTES OVIS, ♂.

This represents a fine *male* specimen of *Dermatodectes ovis* (Gerlach). The figure reproduced by Gamgee is erroneously given as that of a female (see our next plate).

DERMATODECTES BOVIS ? (♂ AND ♀ ?).

These figures represent what are supposed to be a male and female specimen of *Dermatodectes bovis* (Gerlach). They are drawn exactly in the position in which they occur on the slide, and appear as if they might just have parted *à coitû*. The dorsal aspect of the male (?), and the ventral aspect of the female (?), are shown.

SYMBIOTES BOVIS, ♂.

The figure represents the dorsal aspect of a male specimen of *Symbiotes bovis* (Gerlach). The most remarkable peculiarity is the development of an additional pair of appendages (abdominal limbs) which are closely applied to the back of the female, *in coitû*. Another pair of rudimentary abdominal limbs is present in the form of circular acetabula, or suckers; these being on the ventral surface are but indistinctly seen here—they are fully shown in another figure.

SYMBIOTES BOVIS (♂ AND ♀ *in copulo*).

Symbiotes bovis (Gerlach) *in coitû*. Several examples of their occurrence in this state are to be found on E. Nettleship's slides (8, 9, 10?), thus settling accurately the characteristics of this species at any rate. The ventral aspect being presented to the eye of the observer, a good view of all the limbs is obtained, and of the abdominal acetabula in the male, which are rudimentary limbs. The remarkable limbs which terminate the abdomen of the male, being here on the back of the ♀ are here obscured to view; they are seen in the detached figure of the male. Gerlach's figure of the ♂, reproduced in Gamgee (p. 173), is on the whole a good one.

SARCOPTES HOMINIS.

The upper figures represent the male. The two lower figures represent views of the female *Sarcoptes hominis* (Gerlach); that to the left hand gives the dorsal aspect, the right the ventral.

SARCOPTES HOMINIS (BURROW).

In this specimen the track is seen. At the inner (lower end in our figure) the parent *Acarus* ♀, is seen, with an egg protruding, but I suspect this to be from the effects of pressure in mounting the preparation. Five ova are seen in different stages of advancement; the outermost apparently nearly ready to make its exit. Still more outwardly is an empty egg-case. At one part, as will be seen, there is a small side-gallery, and two others appear as if cut across. The characteristic dark masses of excrementitious matter are well seen in the specimen.

LEPTUS AUTUMNALIS (in its immature state), "THE HARVEST-BUG."

The "Harvest-Bug" (*Leptus autumnalis jun.*) is probably the immature condition of some other *Acarus*, characterised in its mature condition by the possession of eight limbs instead of six. What the mature *Acarus* is as yet remains unknown. The figure was taken from a specimen supplied by C. C. Babington, Professor of Botany in Cambridge University, and may therefore be relied on as authentic. I have, too, seen several specimens for sale at the London opticians, and possess one thence obtained. They agree in every respect with this. It is not a little singular that a creature which is a dreadful pest in some neighbourhoods, swarming in countless numbers (*vide* "White's Natural History of Selborne," and common report hereabout confirms the testimony), should be as yet unknown in its perfect state.

COLLEGE NOTES.

BY THE DEAN.

THE "Light treatment" of lupus and other forms of skin disease, according to Finsen's method, is at present attracting considerable attention.

Dr. Stephen Mackenzie has had it in operation at the London Hospital for some time, and more recently a set of the necessary electric apparatus has been brought direct from Copenhagen and established by Mr. Malcolm Morris at Campden Hill.

On the invitation of Mr. Morris a party from the Polyclinic visited his studio a week or two ago, and were much interested in the details of this new procedure. Mr. Morris has already attained results not only in lupus vulgaris, but also in lupus erythematosus and rodent ulcer, which conclusively prove the value of the method, but, as he pointed out to his visitors, it would be premature to claim permanency for the satisfactory results so far achieved.

* * *

THE Conversazione of July 4 was in every way a success. There was an attendance of between 800 and 900 members and guests.

* * *

THE Museum was formally inaugurated by the President, who was assisted in the short ceremony by Sir Joseph Fayrer, Mr.

Hutchinson, Mr. Morris, and Dr. Theodore Williams. Though the clinical collection is not yet complete, the building already contains a large number of valuable pictures of disease, most of which are painted from the life, together with many other varieties of museum specimens of rare clinical value. The collection will be unique, and has been placed at the service of the Polyclinic by Mr. Jonathan Hutchinson. Modesty made him protest against the museum being called by his name, but nothing short of such a designation would either have satisfied the circumstances of the case or been in harmony with the wishes of the members of the College.

* * *

PROFESSOR OSLER'S address attracted a larger crowd than the lecture-hall could accommodate. Fortunately, however, he spoke so distinctly that he could be fairly well heard in the corridors. His oration has been published in full in the leading medical papers, and will be found, in abstract, in the next issue of our own Journal.

It was a powerful plea for the need of post-graduation work in this country; a plea founded upon an extensive knowledge of the subject and a practical acquaintance with the good that has accrued to the general profession in America since post-graduate study has become a recognised necessity of professional life. There, Polyclinics have prospered exceedingly, and it is an evidence of the trend of events that Professor Osler should have felt himself justified in pointing out that this development of post-graduate work in America was becoming so rapidly important that the time might not be far distant when searchers after clinical truth would find its fullest development, no longer in the capitals of Europe, but in the great Polyclinics of the far West. His lecture was a strong expression of surprise that the greatest city of the world should so long have been without an institution which is such an obvious *sine quâ non* if the British graduate is to have any chance of keeping abreast of the professional advances of his day. It was, moreover, an eloquent appeal to the profession of this country to rally to the support of this and kindred institutions lest we become overtaken by the "old fogeyism" of which he spoke so much, and lag behind in the international striving after perfection in the art and science of medicine and surgery.

LANTERN Demonstrations by Dr. Rees, Mr. Cantlie, and Dr. Jobson Horn, were given in the lecture-hall after Professor Osler's oration.

The laboratory was occupied by a large collection of microscopic specimens provided by Captain Pinch, Messrs. Baker and Co., and Messrs. C. and J. Beck.

In room No. 2 the Röntgen ray demonstration of Dr. Harrison Low and Mr. Cossor was most interesting, and the exhibits of Dr. StClair Thomson, Mr. Arthur Cheatle, Dr. Dundas Grant, Professor Leonard Hill, Dr. Alfred Hillier, Dr. Stanton, and Dr. Fletcher Little, attracted much attention. Mr. Freyer's collection of calculi was most "instructive," and Mr. Berry's Cathedral series of pictures was much admired. Mr. J. H. Montague, Messrs. Burroughs and Wellcome, and the Aerators Company, found floor space in the Museum for useful trade exhibits.

Excellent music was provided by the London Orchestral Band under the conductorship of Mr. Algernon Clarke.

* * *

THE thanks of the Council are due to all who kindly aided the success of the conversazione by demonstration or exhibit. They are specially due to Captain Pinch for the excellent manner in which he organised and carried through the various arrangements.

* * *

DURING June eighteen consultations were held, at which 100 patients presented themselves. Many of the cases were of unusual interest. The attendance was well up to the average.

* * *

DR. MADDOX delivered his short course of lectures on "The Ocular Muscles" in June. The attendance as compared with last year was a disappointment, but the lectures again proved attractive and instructive to those who heard them.

* * *

THE next term of Practical Classes will commence on Monday, September 17, and terminate on Friday, October 26. Entries may be made with the Superintendent from now on.

* * *

THE new "Schedule of Lectures and Consultations" for the Autumn Term is completed and will be issued to members within

the next few days. It will be observed that we are again under obligations to many of our most distinguished men for help in this department of our work.

* * *

CLINICAL Lectures will be delivered during September; on the 12th by Dr. Byrom Bramwell, of Edinburgh, and on the 26th by Dr. Sansom.

* * *

THE lecture on the 18th ultimo by Mr. Mayo Robson, of Leeds, on "Chronic Pancreatitis," was a worthy contribution to a subject of which our knowledge is almost in its infancy. The lecturer brought out with striking clearness the close similarity which exists between certain forms of chronic inflammatory disturbance and malignant disease of the pancreas, and by means of illustrative cases pointed out how a differential diagnosis might, in most cases, be arrived at.

He entered into the question of operative treatment in considerable detail, and drew special attention to the methods of avoiding the dangers and pitfalls incidental to surgical interference in such cases.

Mr. Robson's discourse will be published in abstract in our next issue. It was full of interest and information from beginning to end.

* * *

DURING last month two special courses of lectures were delivered within the College—by Dr. Hillier on "The Modern Treatment of Tuberculosis," and by Dr. Bowles on "The Treatment of Threatened Asphyxia." These short courses of lectures on special subjects are intended to be practical and educational. They are a new development and will, it is hoped, tend to increase the usefulness and attractions of the Polyclinic. They are free to members, who are invited to take advantage of the opportunities thus offered for the acquisition of the most recent knowledge in special departments. The interest taken in the courses already given by Mr. Berry, Dr. Hillier, and Dr. Bowles, justifies the hope that future lecturers will be rewarded for their trouble by large and appreciative audiences.

We are glad to be able to announce the following special courses during the Autumn Term: In October by Captain Pinch, on "The Clinical Examination of the Blood"; in November by Mr. Patrick J. Freyer, on "Some Practical Points in the Surgery of the Urinary Organs"; and in December by Dr. StClair Thomson, on "The Surgical Anatomy of the Nose and Accessory Sinuses, including Nasal Suppuration."

* * *

THE name of Professor Osler, of Baltimore, has been added to our list of Vice-Presidents.

* * *

THE question of Hospital Association is now assuming definite shape. A preliminary list of hospitals was approved by the Council at their last meeting, and the matter is referred to the Lectures Committee to deal with in detail. It is desirable that no further time should be lost in arranging for bedside facilities, and though there are many obvious difficulties in the way, there is reason to hope that a little tact and patience will overcome them.

The Council hope and desire to put it, ere long, within the power of members to find through the Polyclinic abundant opportunity for every variety of true clinical study.

* * *

MEMBERS—at any rate most of them—will rejoice to hear that the Council have sanctioned the setting aside of one room in the College where the meditative pipe may be indulged in. Room No. 2 will be fitted up as a reading and smoking room and will be ready for occupation at the beginning of the Autumn Term.

* * *

THE Editor of the Journal has prepared a short statement dealing with the privileges afforded by the Polyclinic to subscribers and members, and the attractions which the College offers, not only to Londoners, but to those who reside in the provinces and abroad. Copies of this leaflet are now in the hands of the Medical Superintendent, and members are urgently requested to possess themselves of a number and to distribute them widely among their medical friends both at home and abroad. It is our common interest to increase our membership, and the Editor has furnished

us in this article with an excellent series of reasons wherewith to tempt our friends and neighbours to range themselves in line with those who have already undertaken allegiance to the creed of betterment in post-graduation opportunities.

* * *

THE College will be closed from July 27 till September 3. These notes will, in consequence, be omitted in the September issue.

* * *

GIFTS TO THE LIBRARY.

Our Library has received during the past month some valuable additions by gift.

From *Dr. Abraham* a large collection of pamphlets on LEPROSY and some bound volumes. Dr. Abraham's gift is a most welcome addition to our collection of works on Leprosy, which will be kept as a special section of the library under the care of the Standing Committee on Leprosy.

From *Dr. Ord* a large number of volumes on various medical subjects.

From the *Hon. Rollo Russell*, of Haslemere, a large collection of Blue Books and Government Health Reports which were used in the preparation of his well-known work on Epidemics.

From *Miss Grant* (through Sir Joseph Fayrer) a selection from the library of her late brother, Alexander Grant, F.R.C.S., Surgeon-Major in the Bengal Medical Service. This gift comprises several series of Indian medical journals.

CORRESPONDENCE AND ANSWERS.

It was possibly merely the love of paradox which led Mr. Treves, in his address to the London Hospital students, to speak with disparagement of genius in reference to medical pursuits. He has, he told them, had the misfortune to encounter genius repeatedly, and had always found it useless for practical pursuits. In this assertion surely he had forgotten his colleague to whom we are indebted for "Jacksonian Epilepsy." What we call genius probably consists in the power, by vigorous deductive effort, to perceive new truth without the laborious collection of evidence. If we are not mistaken it is acknowledged by those best qualified to judge, that Dr. Hughlings Jackson has, by this kind of insight, repeatedly antici-

pated conclusions which subsequent observation and experiment have proved to be true. So far from joining Mr. Treves in regarding genius as "a form of mental disease" we adhere to the old-fashioned notion that it is an attribute of the very highest order of minds.

* * *

LORD SALISBURY'S SPEECH.—In Lord Salisbury's speech at the College of Surgeons' Dinner last week there was a reminder of his old sarcastic vigour in his statement that one chief advantage which he had promised himself from the Fellowship which the College had bestowed upon him was "admission to an Elysium in which there should be no women, no flies, and no men of genius."

* * *

As the College is closed for August we omit the "Appointments for the Month."

* * *

MR. BURDETT COUTTS' MUD.—One of the statements in Mr. Burdett Coutts' letter which most impressed the readers' imagination was that in which he averred that he had seen the sick lying in "three inches deep of mud."

One of the witnesses before the Commission has disposed of this statement by roundly asserting that there is no mud in the country, the dry sandy soil of the district not being suitable to make "mud" of. Let us hear, however, how Mr. Coutts himself explains away his most disquieting statement. According to the report in the *Daily News* he said in reply to the President's query, "You spoke about patients lying in three inches of mud?" "Yes, it was about the third week in April, *when there had been torrential rain*. The hospital to which I referred was in a gully, and no doubt its experience with regard to flood was exceptional. The rain, besides overflowing the ground, penetrated the tents."

Thus, then, it would appear that it was one hospital only—and that pitched in a sort of gully—which was affected, and that the rain had poured in torrents so heavy that even the tent itself could not keep it out. Yet such an incident, lasting perhaps a few hours, is put forward as if a fair illustration of what was going on in the Bloemfontein Hospitals.

* * *

THE late Sir George Burrows used to tell a good story of an old Duke of Portland, long ago dead. Sir George had been attending a lady in the Duke's household, but had never met his Grace. One morning a missive was given to him which ran: "The Duke of Portland begs to hand to Sir George Burrows a prescription for dropsy which has long been in his family, thinking that it may be of use in Mrs. —'s case." The reply was as follows: "Sir George Burrows begs to thank the Duke of Portland for the prescription he has so kindly sent; Mrs. — is, however, now well rid of her dropsy, but she still has organic disease of the heart, and if his Grace has a remedy which will cure her of that, Sir George will be thankful for the prescription." In like tone it might have been quite fair had Lord Lansdowne thanked Sir W. Foster for the remedy (his own supervision) which he had suggested would, had it been duly adopted, have prevented the overcrowding of the Bloemfontein hospitals. That evil had now, however, ceased to exist, but there remained the possibility that in future wars the enemy might break bridges, destroy railway lines, and in various other ways make it difficult to send up medical supplies. If Sir Walter knew of a panacea against such contingencies Lord Lansdowne might have admitted that he would be glad to be informed of it.

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CONSULTATIONS AND LECTURES

From SEPTEMBER to DECEMBER, 1900.

Consultations at 4 p.m.

* Clinical Lectures at 5 p.m.

SPECIAL COURSES OF LECTURES AT 5.15 P.M.

| MONDAYS. (<i>Skin</i>) | TUESDAYS. (<i>Medical</i>) | WEDNESDAYS. (<i>Various</i>) | THURSDAYS. (<i>Surgical</i>) | FRIDAYS. (<i>Eye, Ear, Nose, and Throat.</i>) |
|--------------------------------------|---------------------------------------|--|-----------------------------------|--|
| September 3 College opens | September 4 Dr. W. Ewart | September 5 <i>Surgical Cons.</i> Mr. James Berry | September 6 Mr. Hutchinson | September 7 Mr. J. Griffith |
| September 10 Mr. Hutchinson | September 11 Dr. Seymour Taylor | *September 12 <i>Clinical Lecture.</i> Dr. Byrom Bramwell | September 13 Mr. Hutchinson | September 14 Dr. Dundas Grant |
| September 17 Dr. A. Whitfield | September 18 Dr. James Taylor | September 19 <i>Cons. Pædiatrics.</i> Dr. G. F. Still | September 20 Mr. Hutchinson | September 21 Mr. N. Macle hose |
| September 24 Mr. W. Anderson | September 25 Dr. C. Theo. Williams | *September 26 <i>Clinical Lecture.</i> Dr. A. E. Sansom | September 27 Mr. Hutchinson | September 28 Dr. St. Clair Thomson |
| October 1 Dr. T. Colcott Fox | October 2 Dr. J. E. Squire | October 3 <i>Medical Cons.</i> Dr. Alfred Hillier | October 4 Mr. Hutchinson | October 5 Mr. R. Lake |
| October 8 Dr. Jas. Galloway | October 9 Dr. James Taylor | *October 10 <i>Clinical Lecture.</i> Sir Wm. Gowers | October 11 Mr. Hutchinson | October 12 Mr. Treacher Collins |
| October 15 Mr. Malcolm Morris | October 16 Sir Wm. Broadbent | October 17 <i>Surgical Cons.</i> Mr. J. Cantlie | October 18 Mr. Hutchinson | October 19 Dr. St. Clair Thomson |
| October 22 Dr. T. Colcott Fox | October 23 Dr. Harry Campbell | *October 24th <i>Clinical Lecture.</i> Mr. W. H. A. Jacobson | October 25 Mr. Hutchinson | October 26 Dr. Dundas Grant |
| October 29 Dr. J. F. Payne | October 30 Sir Wm. Broadbent | October 31 <i>Surgical Cons.</i> Mr. Reg'd. Harrison | November 1 Mr. Hutchinson | November 2 Mr. Holmes Spicer |
| November 5 Dr. J. J. Pringle | November 6 Dr. R. L. Bowles | *November 7 <i>Clinical Lecture.</i> Dr. Chris. Childs | November 8 Mr. Hutchinson | November 9 Dr. Herbert Tilley |
| November 12 Mr. Malcolm Morris | November 13 Dr. W. Ewart | November 14 <i>Surgical Cons.</i> Mr. Johnson Smith | November 15 Mr. Hutchinson | November 16 Dr. Dundas Grant |
| November 19 Dr. J. F. Payne | November 20 Dr. S. J. Sharkey | *November 21 <i>Clinical Lecture.</i> Prof. Alfred Carter | November 22 Mr. Hutchinson | November 23 Mr. Holmes Spicer |
| November 26 Dr. Radcliffe Crocker | November 27 Dr. Seymour Taylor | November 28 <i>Cons. Pædiatrics.</i> Dr. W. B. Cheadle | November 29 Mr. Hutchinson | November 30 Dr. St. Clair Thomson |
| December 3 Mr. W. Anderson | December 4 Dr. Guthrie Rankin | *December 5 <i>Clinical Lecture</i> Sir Hector Cameron | December 6 Mr. Hutchinson | December 7 Mr. R. Lake |
| December 10 Mr. Malcolm Morris | December 11 Dr. Harry Campbell | December 12 <i>Surgical Cons.</i> Mr. B. W. Roughton | December 13 Mr. Hutchinson | December 14 Mr. Treacher Collins |
| December 17 Dr. Jas. Galloway | December 18 Dr. C. Theo. Williams | *December 19 <i>Clinical Lecture.</i> Dr. Burney Yeo | December 20 Mr. Hutchinson | December 21 Dr. Herbert Tilley |

October 12th, 19th, and 26th. Mr. HAYWARD PINCH—"The Clinical Examination of the Blood."

November 2nd, 9th, and 16th. Mr. P. J. FREYER—"Some Practical Points in the Surgery of the Urinary Organs."

December 3rd, 10th, and 17th. Dr. ST. CLAIR THOMSON—"The Surgical Anatomy of the Nose and Accessory Sinuses, including Nasal Suppuration."

GUTHRIE RANKIN, M.D., *Dean.*

A. E. HAYWARD PINCH, F.R.C.S., *Medical Superintendent.*

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. III., No. 9.—SEPTEMBER, 1900.

THE ADVANTAGES OF CIRCUMCISION.

THE sentence recommending the universal adoption of circumcision with which one of our Leaders for July concluded, has produced expressions of desire for explanation as to what the supposed advantages of the practice really are. The importance of the topic as a social question induces us to offer a somewhat detailed reply. It is probably one in which many besides those who have addressed us take interest.

The first and most obvious advantage of removal of the foreskin is that it promotes local cleanliness. This is of really great importance in childhood. In adults the habit of withdrawing the skin and washing the glans has usually been learned, though even in them it is often not practised with the frequency which is desirable. In children and young persons it is, as a rule, never attempted; most young boys would regard the attempt to do so as an act of indecency, and in many if it were made paraphymosis would be the result. Apart from this risk it would be most injurious to the morals of the child if the practice were taught and insisted on. Yet the accumulation of smegma and its decomposition is a source of annoyance and irritation to many boys. Now any irritation of the surface of the glans penis is liable to produce reflex excitement precisely of the character which it is most desirable to avoid in

youth. The late Mr. Blizzard Curling, who took great interest in this subject, believed that this kind of irritation had a powerful influence in disposing to masturbation. He endeavoured to collect facts as to the relative prevalence of that habit amongst Jews and Christians, but although he arrived at impressions which were very definite, we believe that he failed to obtain facts which justified publication. It is obviously a subject which it is almost impossible to deal with by statistical methods. On theoretic grounds, which will be obvious to all, we may, however, accept the belief that it cannot but be prejudicial to a boy to have this part of his person kept in a state of irritation. Everything which draws attention to it is injurious to him.

In middle life to many men the possession of a prepuce is a source of more or less habitual annoyance. Seborrhœa, balanitis and herpes are common, and to some persons very troublesome. As old age threatens, comes the danger of cancer, which, although it is to be admitted, very rare excepting to those who suffer from phymosis, is a real and considerable risk to them. The number of both middle aged and senile persons who would be both more comfortable and more secure if they had been circumcised in infancy is large.

The argument in favour of the general practice of circumcision which, however, carries most weight is that it would tend to greatly reduce the prevalence of syphilis. The writer many years ago collected statistics as to gonorrhœa and syphilis in Jews, which proved that whilst the former was quite as common amongst them as amongst Christians the latter was much less frequent. This seemed to show, what perhaps scarcely needed proof, that it is not to stricter morality but to some adventitious advantage that the comparative immunity of Jews from syphilis is due. The only advantage which can be alleged is the absence of the prepuce. Many other observers have since given corroboration to these opinions. It would indeed be difficult to contrive an appendage more likely to facilitate the implantation of the syphilitic virus than the prepuce. By its folds of delicate mucous membrane are kept constantly in a condition the most suitable for the retention and absorption of any virus which may be brought into contact with them. No other measure for the prevention of syphilis which has ever been proposed can stand, as regards efficiency, in the

least competition with this. Its effects would be enormous. It is to be remembered also that most of the others, such as the inspection of prostitutes, would have a collateral influence prejudicial to morality. Professedly making irregular sexual intercourse less dangerous, they might very possibly increase its amount to such an extent as to more than counterbalance their supposed advantages. They are also very injurious to the sense of decency, to say nothing of modesty, and without question detrimental to the moral conscience of any community in which they are practised. It would not be so with circumcision. Effected in early infancy, and with other avowed objects in view, it would silently become the means of preventing on a large scale the prevalence of a loathsome and misery-producing disease. The extent to which this diminution of risk might tend to increase sexual folly would probably be infinitesimal. The gain would be without any drawback. Let it be always remembered that a large proportion of the syphilis extant is contracted by young men who are by no means habitual in their disregard of continence. It is also a most important consideration that with a contagious disease of this kind every single case becomes a possible focus for further spreading and that the prevention of a single infection often means the prevention of many.

It may be allowed to be an open question whether the removal of the prepuce tends to any appreciable extent to increase the power of sexual control. That its influence, so far as it has any, would be in that direction may be confidently asserted. The only physiological advantage which the prepuce can be supposed to confer is that of maintaining in a condition susceptible of more acute sensation than would otherwise be the case that portion of the sexual apparatus immediately concerned in the act of intercourse. It may be supposed to increase the pleasure of the act and also in some degree to increase the impulse to it. These are advantages, however, which in the present state of society can well be spared, and if in their loss some degree of increase in sexual control should result all reasonable men would be thankful.

SOME FALLACIES AS TO SYPHILIS.

THE recent discussions as to the supposed possibility of making a diagnosis between yaws and syphilis have revealed in many directions the existence of much misapprehension of facts as to syphilis itself. It may be worth while, therefore, to devote a few paragraphs to an endeavour to clear the ground in this direction.

If we go back to the older writers we find authors such as Maxwell asserting, in conformity with the creed of their day, that a man might have syphilis many times, but yaws only once. Maxwell's words were: "Syphilis may occur frequently from distinct infections." In making this assertion he probably left out of sight the difference between infecting and non-infecting sores, and thus counted all venereal sores as syphilis. This view is supported by his statement in a preceding paragraph that "Syphilis appears in six or eight days after contagion; yaws takes from six weeks to three months." We now know that although a venereal sore from contagion may appear within a few days of exposure, it is usually not a syphilitic one, and that the real period of incubation for syphilis, that preceding the constitutional symptoms, is exactly that assigned by him to yaws. Maxwell wrote in 1839, and after his time there arose the opinion that syphilis could occur but once in a lifetime. We now know that the truth lies between the two creeds—that most unquestionably second and even third attacks of complete syphilis may occur, but that they are comparatively rare. We know that a developed attack of syphilis does, like vaccination, confer a sort of immunity; complete and lasting in some cases, imperfect and transitory in others. We know that this is, to a considerable extent, a matter of individual peculiarity, and that it is possible in some persons for the interval of immunity to be exceedingly short. In some instances a hard chancre is auto-inoculable, and cases have occurred in which within a year of the first syphilis another well-characterised chancre has been acquired. It is, if we mistake not, exactly the same with vaccination, some persons being susceptible of successful revaccination after very short intervals. It is even so with small-pox itself, there being on record

one instance in which a woman had six attacks of small-pox, and the last was so little modified that it proved fatal. Yet no one can doubt that respecting syphilis, vaccination and variola, the rule is that an attack is protective for a longer or shorter space of time. It appears to be just the same with yaws, for carefully recorded observations of second attacks are available, and the most recent authority, Dr. Nicholls, is of opinion that the immunity conferred is not absolute and is impaired by time.

A fallacy respecting syphilis which appears to be very prevalent is to the effect that the full rôle of phenomena is to be expected in every case. Nothing is probably further from the truth. As a matter of fact complete cases are, perhaps, rather exceptional. The chancre may be omitted, or, in other words, it may wholly escape observation although carefully looked for. The bubo may be omitted, the sore throat may be omitted, and so may the eruption. Some observers write as if iritis were an ordinary feature of constitutional syphilis, and its absence in yaws is alleged as a means of diagnosis and proof of essential difference. Now the truth is that iritis is a very rare epi-phenomenon of syphilis, and possibly does not occur once in 500 cases. Until the time of Lawrence—who to the knowledge of general surgery joined that of a specialist as one of the Moorfields staff—no one of the many who had studied syphilis had ever associated iritis with that disease. The ulcers in the tonsils, which are so common and so well known in the secondary stage of syphilis, are by no means constantly seen. Their occurrence depends probably upon the proclivities of the individual, the climate, and the weather. Possibly not more than half the subjects of secondary syphilis in England ever show any affection of the tonsils or the mucous membrane of the mouth. We speak of patients not treated by the early use of specifics, for of those who are so treated the proportion who have sore throats is certainly far less. It is difficult in these days of the all but universal employment of mercury to collect data illustrating the natural course of syphilis when not interfered with. Under modern methods of early and continuous employment of mercury, eruptions on the skin are but very seldom seen, and never in any severity, but it is probable this omission occurs also not seldom quite independently of antidotal treatment.

We must note another most important fallacy in the assumption

that erratic chancres, that is those situate on some part other than the genitals, are usually well characterised and easy of diagnosis. The fact is that they are just the reverse. Midwifery chancres on the fingers of medical men are so misleading in appearance that they are scarcely ever diagnosed until the eruption makes its appearance. On other parts of the skin they are yet less likely to excite suspicion. Characteristic induration is a condition met with only exceptionally on any other part than the genitals. As is well known in the female sex it is not often present even on the genitals. Sores on the skin which may prove introductory to syphilis, that is, which are primary chancres, may be of very insignificant appearance, and of very short duration, or, on the other hand, their very magnitude may be the misleading feature. As a rule certainly no diagnosis of such sores is ever made, or even suspicion excited, until the constitutional symptoms have appeared. Now in the case of yaws the supposition is that the primary sore is always on the skin at some part distant from the genitals; what wonder then that it should frequently be overlooked, and that when recognised it should escape diagnosis as a chancre.

The last fallacy which we will mention is the notion that the subjects of syphilis are always seriously ill. As a matter of fact many pass through all the stages of constitutional affection and suffer next to nothing. Nor most certainly is this always to be credited to the effects of treatment. The disease is one which may fall with terrible severity on one victim and leave another almost unhurt.

THE FAROE ISLANDS.

THE Faroe Islands present some interesting peculiarities. Although north of the Shetlands, their winters, owing to the Gulf stream, are not very cold. Both sheep and horses can live the year round in the open air. There is little or no low-lying land, the cliffs rising precipitously from the sea. There is no wood, but the mountain valleys supply abundant peat. They are emphatically a land of mist and damp, and thus the growth of mosses has been favoured. It is said that all the inhabitants become asthmatic. Turnips and potatoes thrive well; but the only cereal which flourishes is barley, and it is not always a sure crop. The chief occupations are fishing, catching wild fowl, and feeding sheep. Although originally peopled from Norway, they now belong, like their yet more northerly neighbour Iceland, to Denmark. The population is said to be remarkably healthy; the average duration of life in Denmark being thirty-six years, whilst that in the Faroes is forty-four and a half. Old men are said to abound, and marriages in which the age of the bridegroom is from 75 on to 90 occasionally take place with satisfactory results. A visitor to the Faroes, who recorded his experience in the *Cornhill Magazine* for May, 1886, wrote respecting the tendency to catarrh: "Nevertheless, though favourable to longevity, the climate of Faroe, by its excessive dampness and fogs, seems to inoculate most people with the most tenacious of colds. Be the weather what it may, 60 or 70 per cent. of the inhabitants are sneezing, coughing, or clearing their throats; and the prevailing serious complaint appears to be lung inflammation. It is curious, moreover, that strangers coming into the isles for a prolonged stay or a permanent residence do not at first suffer appreciably from the humid and changeable climate. On the contrary, they are in better health than usual; but at the end of a few years they give way to the local epidemic, and wheeze with the best acclimatised natives." The same author speaks of the difficulty of getting and keeping anything in a state of dryness, and

illustrates it by stating that "guns rust in a day, even in a warmed room. Clothes from the wash, unless constantly aired, have a trick of adhering together. Biscuits and the bread in use are always flexible like leather."

A remarkable proneness to epidemics of influenza, or of a severe contagious catarrhal affection closely resembling it, used to be asserted by medical reporters, and a creed prevailed that the first vessel which visited the islands in the spring always brought this disease. This opinion has, however, been discredited of late by the more intelligent natives. Hirsch had already, with his customary sagacity, pointed out its improbability, more especially as it was asserted that often the crews of the vessels bringing it remained healthy. We may take it as fairly certain that the Faroese are very prone to catarrh, and they do not become in any degree acclimatised, but habitually suffer even more than strangers.

It is obvious that many fallacies underlie the assertion that the average duration of life is greater in these islands than on the mainland. Their almost entire exemption from the exanthemata is one. Given conditions favourable to the survival of young children, and the average length of life will at once be increased, although there may be no remarkable exemption from the maladies incident to adult age. The community is, however, practically free from syphilis, and from the evils consequent on the abuse of alcohol, and these are two not unimportant factors. It would be of great interest to know whether cancer is common, and also whether rheumatic affections prevail. The conditions as regards moisture, prevalence of fog, &c., may be regarded as the antithesis of those found in the high and dry plateaus of the Orange Free State and the Transvaal. It is reported that rheumatism is seldom met with in those localities, and one of the supposed hardships attending the deportation of Transvaal lepers to Robben Island is that they suffer much from rheumatism in consequence of the change to a low level and sea-fogs.

The diet of the Faroe Islanders differs from that of Iceland and the Norwegian coasts, in that mutton and bird-flesh are abundant. There is also a considerable consumption of whale-fat. Thus the dependence upon dried or salted fish is far less, and it is not without interest in this respect to note that while leprosy still exists in

Iceland and Norway, it is reported (Hirsch) to have died out in Faroes about the middle of the eighteenth century. In this matter the history of the Faroes is similar to that of the Orkneys and Shetlands, and similar conditions have prevailed. In all these islands the subsidence of the disease was gradual and apparently spontaneous, and in no respect connected with attempts at segregation.

Typhoid fever is unfortunately not uncommon, and sometimes of a malignant type, but malaria is unknown, and there has been no case of small-pox since the year 1705.

Glandular scrofula is said to occur only in the descendants of Danes, and to be almost unknown amongst the natives. The free use of whale fat and oil may have some influence in this direction. Syphilis is said to have been imported for the first time in 1844, when during the two following years twenty cases resulted (Hirsch, vol. ii., p. 71).

It may interest some of our book-loving readers to know that a copy of the "Castel of Helth" might have been bought last week for twenty-six shillings. The following is from the auctioneer's catalogue :—

601 Elyot (Sir T.) The Castel of Helth, **black letter** (stained), 1541 ; Patricii Opuscula, ed. Waræus, 1656, and 8 others.

The first edition was published in 1534 and dedicated to Cromwell. Elyot was a friend of Linacre and himself an invalid. The book was a treatise on popular medicine.

At the same sale a "Guide to Watering Places," published in the earlier years of the century, fetched thirty-one shillings. It was catalogued as follows :—

605 *Guide to the Watering and Sea-Bathing Places, maps and 36 coloured plates (2 folding and 2 plain), 12mo, calf.* 1803.

ALL members of the medical profession are, or ought to be, interested in the details of house building. More especially at the present time should those practising in country districts concern themselves as to the cottages of the poor. The following extract from an article in the *Daily News* may serve to direct attention to an interesting department in the Paris Exhibition:—

“The French record of experiment in workmen’s dwellings should be very instructive to the English artisans who are to visit the Exhibition. M. Meriot produces very pretty designs for cheap houses in the suburbs of Paris. A society for the building of cheap and healthy houses for the working classes in unhealthy Marseilles is making good progress. Among the many drawings, plans, and models is a picture of a ‘cité ouvrière,’ workmen’s town, at Pouilly sur Charlieu (Loire). A cotton workers’ model town, provided with wide avenues, and excellently sanitated, it is let at a uniform rent of half-a-crown a week for each dwelling. Through a society at Passy-Auteuil, workmen become owners of detached houses after payment of a low rent for twenty years. A Paris society, started five years ago under the title ‘Ma Campagne,’ deserves special mention. The members are clerks and assistants on the ‘Grands Magasins,’ Louvre. Sixty of them clubbed together to buy sites and build houses in some locality removed from the noise and ‘l’atmosphère viciée de la Grande ville’ (it is not as bad as London’s), but within easy distance of their place of business. Their employers generously lent them money at a low rate of interest. Not only has most of the loan been already repaid, but the associates have built twenty houses at Viroflay, ‘au milieu d’une nature riante,’ and their very successful experiment seems destined to have many imitations.”

THE observation of Dr. Livingstone that syphilis appears to die out in negro populations has often been quoted. It is, however, very doubtful whether it is founded on fact. It is very possible that it only changes its name to that of Yaws.

Captain Burton, speaking of the native races of Equatorial Africa, negroid and negroes, writes:—

“As might be suspected amongst an ignorant and debauched race coming in contact with semi-civilisation, the lues has found its way from the island of Zanzibar to Ujiji and into the heart of Africa. It is universally believed, both by the natives and by the Arabs, who support the assertion by a host of proofs, to be propagated without contact” (by this is probably meant *sexual* contact). “Such, indeed, is the general opinion of the Eastern world, where perhaps its greater virulence may assimilate to the type of the earlier attacks in Europe. The disease, however, dies out, and has not taken root in the people as amongst the devoted races of North America and the South Sea Islands. Although a malignant form was found extending throughout the country, mutilation of the features

and similar secondaries were not observed beyond the maritime region. Except bluestone mineral, drugs are unknown, and the use of mercury and ptyalism have not yet exacerbated the evil. The minor form of lues" (gonorrhœa?) "is little feared, and yields readily to simples; the consequences, however, are strangury, cystitis, chronic nephritic disease, and rheumatism."

We may understand that our author wrote *currente calamo* and with considerable self-confidence. Although Captain Burton deals very freely with medical terms, he had not had a medical education, and his knowledge of anatomy was not sufficient to save him from such blunders as that of stating that the negro *cornea* is not black.

Captain F. Elton, in his account of an exploration of the Limpopo River in 1871, confirms the above statements as to the possible prevalence of syphilis amongst the native races:—

"The Amatonga," he writes, "suffer from the venereal disease, but exanthematous diseases do not appear to have passed through the regions lying on the Lipalule, Lower Limpopo, and the Uncomogazi Macheus town. Bamanywato is contaminated with syphilis, and it is to be feared the scourge will pass through the Makalala, &c."

DR. CLAUS HANSEN, of Bergen, has stated his opinion that tuberculosis is increasing in Norway. He thinks that during thirty years of which he has had personal experience phthisis in the Bergen district has increased 80 per cent. This is of interest in connection with the alleged decline of leprosy. Much the same facts have been asserted in the case of Iceland. Is there any law of substitution at work?

IN a recent report on leprosy in Portugal (Dr. Falcao) it is estimated that in a population of less than five millions, one thousand five hundred are affected. The disease does not restrict itself to any one focus, the cases being scattered about the country and no district being wholly exempt. The majority are, however, near the coast. These facts are precisely similar to those observed in South Africa, and, it is needless to point out, they give support to the belief that the disease is in some way conveyed by food and not by personal contagion. If the latter, one would expect to find local prevalence instead of wide dissemination. Dr. Falcao admits his belief that the disease is but very slightly contagious.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

PANCREATITIS, WITH ESPECIAL REFERENCE TO CHRONIC PANCREATITIS,

*Its Simulation of Cancer of the Pancreas and its Treatment by
Operation, with Illustrative Cases.*

BY A. W. MAYO ROBSON, F.R.C.S.ENG.

July 18, 1900.

GENTLEMEN,—To be asked to lecture before an audience of post-graduates must always be considered an honour, but when the request comes from such a distinguished body as the council of the Medical Graduates' College and Polyclinic one can only feel that to the honour is added the pleasure of compliance. Fortunately, too, I had a subject which I wanted an opportunity of bringing forward, and I hope that I may have the benefit of your criticisms and the advantage of help from your experience in a class of cases which has hitherto, scarcely, if at all, been generally recognised, but which I believe to be not very uncommon.

Before proceeding to consider the subject of chronic pancreatitis specially I think that it will tend to the elucidation of my subject if I make a few remarks on pancreatitis generally.

PANCREATITIS.

When it is borne in mind that the pancreas is a racemose gland with its various channels opening into a duct which opens along with the common bile-duct into the second part of the duodenum—a channel usually containing septic organisms, and frequently liable to catarrh and other disorders—it is not surprising that inflammation should frequently occur in it. Just as in the liver we may have acute and chronic catarrh of the ducts, infective and suppurative cholangitis, and inflammation of the inter-lobular tissue ending in

cirrhosis, so in inflammation of the pancreas we may have any one or more of those affections, though as yet we have not learnt to recognise acute or chronic catarrh of the pancreatic ducts apart from jaundice, or infective and suppurative inflammation of the ducts apart from abscess of the pancreas itself. As our means of diagnosis become more perfect I venture to predict that these affections will be more frequently recognised and awarded their proper place in medicine.

I have seen cases of discomfort with some swelling at the epigastrium associated with dyspepsia and ague-like attacks but without jaundice, or with only very slight jaundice, which I thought might be explained on the hypothesis of infective inflammation of the pancreatic duct, the cases having cleared up under general treatment. I have also seen the same symptoms associated with more pain, irregular fever, more marked swelling, and tenderness over the pancreas and discharge of pus by the bowel from time to time, but without any collection sufficiently large to form a distinct abscess. In a case of this kind seen lately the question of operation was raised, but in the absence of distinct abscess of the pancreas it was not pressed and the patient is recovering. I think that this may have been an affection of the pancreas analogous to suppurative cholangitis.

Causes.—The essential and immediate cause of the various forms of pancreatitis is bacterial infection, this having been positively proved in a number of cases both clinically in the human subject and experimentally in the lower animals, but as in inflammatory affections of the liver and bile-ducts we look for extrinsic causes, so in pancreatic diseases we find biliary and pancreatic lithiasis, injury, gastro-duodenal catarrh, ulcer and cancer of the stomach, pylorus, or duodenum, and zymotic diseases such as typhoid fever and influenza, to be determining factors, though in some cases pancreatitis has come on suddenly in persons in robust health, and the determining cause has been beyond recognition. Though the infection may arise from the blood as in pyæmia, or by direct extension from the neighbouring tissues as in ulcer of the stomach, yet the most usual channel is through the duct, as in the cases related below arising from gall-stones in the common duct, and from gastro-duodenal catarrh.

Symptoms.—It seems to me more convenient to consider pancreatitis clinically under the headings of (1) acute, (2) sub-acute, and (3) chronic, which does not interfere with the pathological classification of acute pancreatitis into hæmorrhagic, suppurative, and gangrenous. The symptoms of pancreatitis are very variable and differ in the separate forms. It is a disease without pathognomic signs and a correct diagnosis is usually only arrived at by a careful study of the history, mode of onset, and combination of symptoms.

1.—ACUTE PANCREATITIS.

This is usually ushered in by a sudden pain in the superior abdominal region, accompanied with faintness or collapse and followed sooner or later by vomiting. It is almost constantly accompanied by constipation, so that it is quite usual for these cases to be mistaken for intestinal obstruction at first. The obstruction, however, is not absolute, flatus passes, and a large enema may secure an evacuation; if the patient survive for several days diarrhœa may supervene. The pain may be so severe as to produce syncope or collapse, and though the pain does not quite pass away it has a tendency to be paroxysmal and to be increased by movement; it is associated with well-marked tenderness just above the umbilicus or between it and the ensiform cartilage. The pain is soon followed by distension in the superior abdominal region which may become general and usually does so in the later stages, and by vomiting, first of food then of bile. The vomiting may be severe and each seizure may aggravate the pain, but at times vomiting may not be a prominent symptom. Slight icterus from associated catarrh of the bile-ducts is usually present and deepens the longer the patient survives. The aspect is anxious and the face is pinched, resembling the facies of peritonitis, which in fact may be present. The pulse, which is rapid and small, is a better guide than the temperature, which may be normal, subnormal, irregular, or high. Delirium comes on in the later stages. The distension, pain, and tenderness prevent an exact examination of the pancreas, which would otherwise be found enlarged. Death usually supervenes from the second to the fifth day from collapse, though in the less acute cases life may be more prolonged. Acute infective pan-

creatitis thus takes on the form of acute peritonitis starting in the superior abdominal region. If life be prolonged the case comes under the category of sub acute pancreatitis, and in that case the onset is usually less grave, though often equally sudden.

2.—SUB-ACUTE PANCREATITIS.

This may have a sudden onset with acute pain and vomiting associated with constipation, but the collapse is not so marked and may even be absent; the upper abdominal region does not become so rapidly swollen, and vomiting is less severe and less prolonged. At other times the onset is more gradual, though the symptoms may be similar. Tenderness over the pancreas is well marked and on account of the tympanites being less than in the acute form it may be possible to feel the swollen gland, especially under an anæsthetic. Constipation gives place to diarrhoea, and pus or blood may be noticed in the stools, which have a very foetid odour. The pulse will be less rapid and less thready than in the acute form, and the temperature is more irregular. I have seen the temperature reaching 104° and 105° F., and yet the pulse to vary between 90 and 110. The morning temperature may be normal and the evening temperature high for several days or even weeks. Rigors may occur and may be repeated from time to time. The pain occurs in paroxysms, but there is also a constant dull pain at the epigastrium. The patient may lose the more urgent symptoms and appear to be really improving, but the loss of flesh and feebleness continue and relapses usually occur, leaving the patient each time more and more feeble until death supervenes from asthenia. Albuminuria is pretty constant, but glycosuria is rarely present and lipuria is an uncommon symptom.

If an abscess develop the pus may form a tumour projecting in the superior abdominal region and forming a tender swelling behind the stomach, or perhaps coming to the surface above or below that viscus; or it may burrow into either loin forming a perirenal abscess, or passing under the diaphragm it may form a subphrenic abscess. Occasionally the pus may follow the psoas muscle and form a subperitoneal abscess in the iliac region, or even passing over the brim of the pelvis it may collect in the left broad ligament.

I have seen these several terminations in cases either under my own care or under the care of colleagues and I have operated four times for abscess of the pancreas. Sometimes the abscess bursts into the stomach and is vomited, or into the bowel and is voided per anum, after which diarrhœa may continue and pus may be seen from time to time as any fresh collection forms and bursts. I have seen both of these methods of evacuation of the pus. With the evacuation of the abscess relief occurs for a time and the temperature improves, but relapses usually occur and a mild form of septicæmia persists with a hectic temperature. Death is the usual termination, but recovery may occur after a tedious and prolonged illness, as in the case now related.

CASE 1.—On March 17th, 1900, I was asked by Dr. J. Glen, of Middlesbrough, to see a female patient, aged 26 years, when I obtained the following history. The patient was first attended the last week of December, 1899. Her symptoms then indicated a chronic form of dyspepsia with recurrent attacks of diarrhœa, the latter associated with indurated fæces. No relief from treatment resulted. The main symptoms at this time were general tympanitic condition of abdomen with tenderness over the sigmoid flexure, no acceleration of pulse, and no rise of temperature. About the second week in January, 1900, the diarrhœa still persisting, a good deal of fresh blood was present with each evacuation—these giving one the idea of dysentery. Then retching and vomiting set in, but this condition was probably set up by the free exhibition of powder of ipecacuanha. This condition continued more or less for upwards of a fortnight when improvement set in. The tympanites disappeared, the tenderness of the left groin became less, there was less sickness, and a desire for food returned. The diarrhœa abated, there being only one or two evacuations in the twenty-four hours, the motions being formed. The improvement continued till the second week in February. The patient at this time having gained flesh, was daily gaining strength, and was able to sit up in her dressing-gown for a time each day. A relapse took place, accompanied with much pain in the epigastric region, constant sickness, return of diarrhœa and blood in the stools, and rapid emaciation, and quick pulse and rise of temperature. This condition persisted in spite of all treatment. There had never been blood in the vomited

matter except once, when there was a slight streak as if it might have come from the pharynx during the act of severe retching. Since the relapse there has developed a dull area with tenderness over the pancreas, but the degree of tenderness varies from day to day. At one time there was retention of urine, afterwards incontinence; no albumin or sugar was present. Hæmorrhage was very profuse, the blood being gruel-like and mixed with stools which were very offensive. Dr. Glen showed me the report of the Clinical Research Association of an examination of the fæces which contained some blood and pus but no cells suggestive of growth and no tubercle bacilli. When I saw her the patient was looking very ill and emaciated, with feeble, quick pulse; there was tenderness in the superior abdominal region with rigid recti, but not along the course of the colon either on the right or the left side. Examination under an anæsthetic revealed a swelling in the situation of the pancreas, but no fluctuation could be made out. As there was resonance in front of it, it was clearly behind the stomach, and from its position it was above the colon. Before the anæsthetic the patient said there was very great tenderness on pressure over the swelling in the epigastrium. The rectal examination was negative, except that there was ballooning. I made a diagnosis of suppurative pancreatitis, the abscess having discharged into the bowel. I advised five grains of salol, two grains of quinine, and half a grain of opium, to be given thrice daily, the patient to be watched with a view to the testing of her temperature, pulse, &c. Plasmon and somatose dissolved in broth, tea, &c., were ordered as the patient could not take milk. The question of operation was raised and dismissed to be further considered in about a week or ten days, as she was at the time too feeble to bear even an exploratory incision. From this time improvement steadily occurred, and when I saw her again in a fortnight she was picking up distinctly, though there was still well-marked tenderness over the pancreas. In June she had gained nearly a stone and a half in weight, looked much better, and could take her food well; there was, however, still a little rigidity of the recti and some tenderness, though no distinct tumour of the pancreas. The diarrhœa had disappeared, and there was neither pus nor blood in the motions.

3.—CHRONIC PANCREATITIS.

Chronic pancreatitis, at first hypertrophic but later cirrhotic, is usually considered to be a very rare disease, but experience would lead me to believe it to be a much more common affection than the acute or sub-acute forms, and I think that some cases put down as malignant disease of the head of the pancreas and terminating fatally may be cases of chronic interstitial pancreatitis. My reason for this belief is shown in the cases related below, selected out of 17 cases on which I have operated. My experience has resulted from my having operated on a large number of cases of jaundice depending on obstruction to the common bile-duct; the obstructive jaundice, wasting, paroxysmal attacks of pain and ague-like seizures having given rise to the suspicion of gall-stones, and the absence of relief by medical treatment having rendered surgical treatment necessary. My first case of this nature was a revelation to me, as the patient was extremely ill before the operation which was, in fact, undertaken too late; and as there was the opportunity of a *post-mortem* examination the absence of malignant disease or of other cause than the chronic pancreatitis and associated jaundice to account for the death was directly proved.

This form of pancreatitis is quite distinct from the acute or sub-acute form, though I think it is probable that some of the latter cases end in chronic interstitial pancreatitis. It probably usually arises by extension of the inflammation from a chronic catarrh of the pancreatic duct extending from a gastro-duodenal catarrh, though it is frequently associated with biliary or pancreatic lithiasis, or with gastric, pyloric, or duodenal ulcer. Its course varies. The onset may be quite gradual and painless, or may be ushered in by a severe pain at the epigastrium followed by jaundice resembling a gall-stone attack and associated with nausea and vomiting, and perhaps followed by a feeling of chilliness or even a rigor. The pain, however, is not over the gall-bladder and does not pass round the right side to the subscapular region, but is central and passes backwards to the midscapular region or round the left side, thus resembling stomach rather than gall-bladder pain. The tender spot is usually an inch above the umbilicus in the middle line and not over the gall-bladder as in cholelithiasis. When once

jaundice has come on it tends to deepen with each attack until it becomes continuous and chronic. The paroxysms of pain may be repeated more or less frequently or there may be no paroxysmal pain, merely a dull ache deeply seated, burning and boring in character. A swelling of the pancreas may sometimes be made out, but as the recti are rigid because of the pain and tenderness in the epigastrium, it can usually only be discovered under anæsthesia.

Loss of flesh and strength are well-marked symptoms in all cases. Vomiting may in some cases be absent, but there are usually a want of appetite and flatulent dyspepsia, and always a sense of fulness and weight at the epigastrium for some time after food. Jaundice is not necessarily present at first, though it is usually present at some stage of the disease and is often well marked, but, as was pointed out some years ago by Dr. Walker of Peterborough, the stools are white even when the pancreatic fluid alone is absent from the intestine. Diarrhœa is often present and the stools are offensive and may be fatty. Albuminuria is common and glycosuria may occur, but the latter is probably only present in cases where the whole gland is affected. Fever may be absent, but in some cases the temperature runs a hectic course, always rising in the evening and falling in the morning. This is especially the case where ague-like paroxysms occur. These varieties probably depend on the character of the infection in the pancreatic and bile-ducts and also on the amount of obstruction present. Where jaundice is present the pulse may be abnormally slow, and even when the temperature is raised the pulse-rate is not much elevated, though the character of the pulse may be poor. In the later stages, especially if the disease be associated with jaundice, hæmorrhages from the nose and the bowel, vomiting of blood and petechiæ in the skin show marked blood degeneration, and death ensues from increasing weakness.

In the more chronic cases, especially when there is contraction of the head of the pancreas, there will be found a tumour formed by the distended gall-bladder, just as there is in cancer of the head of the pancreas, for which disease chronic interstitial pancreatitis is then apt to be mistaken and a hopeless prognosis given. In such cases the gall-bladder will be found to be distended with mucus, the

bile which first filled it having become gradually absorbed, the backward pressure having prevented fresh bile from entering the ducts. This may occur so gradually as to be painless and then the gall-bladder is free from tenderness, which is seldom the case when the distension is due to gall-stones.

Diagnosis.—The diagnosis of chronic interstitial pancreatitis has to be made from gall-stones in the common duct, cancer of the head of the pancreas, cancer of the liver and bile-ducts, and chronic catarrh of the bile-ducts. From gall-stones the diagnosis is of no great importance, since the two diseases are often associated and the treatment is the same; nevertheless, it may be possible to make a diagnosis of gall-stones by the sequence of long antecedent history of spasms without jaundice, then by a severe attack of pain followed by jaundice, and after a time by recurring pains with increase of the icterus associated with ague-like attacks. The absence of tumour is more common in gall-stones than in chronic pancreatitis, though in the latter the gall-bladder may be found contracted at times. Although in pancreatitis there is usually less pain, at times the paroxysmal attacks may be equally severe as in gall-stone seizures. The tenderness in the latter case, however, will be over the gall-bladder, and in the former at the middle line where the swollen gland can sometimes be felt, especially if the examination is made under anæsthesia; moreover, the radiating pain in gall-stones is towards the right and in pancreatitis towards the left or to the mid-scapular region. In cancer of the head of the pancreas the onset is usually gradual and painless, and the disease generally occurs later in life, usually after 40 years of age. It is preceded by general failure of health, and when the jaundice supervenes it becomes absolute and unvarying and is nearly always associated with a tumour of the gall-bladder, which generally attains a large size and shows no tenderness on manipulation. The liver enlarges from the biliary stasis, but there are no nodules to be felt. In some cases of cancer of the head of the pancreas a hard nodular tumour may be found on the inner side of the distended gall-bladder. Extremely rapid loss of weight and strength with increasing anæmia, but without ague-like seizures, is very characteristic, and it is common for there to be an absence of fever with a slow feeble pulse and later ascites with œdema of the lower limbs. Cancer of the common

bile-duct is rare, but when present may resemble, and is usually associated with, gall-stones. In cancer of the liver, the irregular enlargement, the nodular feel, the rapid deterioration of health, the less intense jaundice, and the absence of fever and paroxysmal pains will usually enable a diagnosis to be made. Chronic catarrh of the bile-ducts is usually associated with an absence of symptoms, except jaundice and some loss of flesh. The entire absence of pain and fever with the relief by treatment usually give rise to little difficulty in establishing a diagnosis. In many cases a diagnosis will only be made by an exploratory operation, then the enlargement of the pancreas can be readily felt, or if the tumour be small the head of the pancreas may be found to be hard and perhaps nodular like scirrhus. If ascites be present the tumour will probably be malignant. The lymphatic glands in the lesser omentum may be enlarged in both cancer and chronic pancreatitis, but in the latter they will be discrete and soft, in the former hard and perhaps infiltrating. Adhesions are usually associated with chronic pancreatitis, but are generally absent in cancer.

(To be concluded.)

THE TREATMENT OF LUPUS VULGARIS, MORE ESPECIALLY BY THYROID FEEDING.

BY DR. J. J. PRINGLE.

Monday, May 6, 1900.

GENTLEMEN,—The subject which I wish to bring before you to-day is that of lupus vulgaris—almost entirely with regard to its treatment. Of course the ideal treatment of this disease is complete removal of the part by EXCISION, with subsequent skin grafting, and this is possible in a very large number of instances, as has been recognised in late years. In this connection I think I may, without appearing invidious, refer to the very remarkable successes attained by Mr. William Anderson, of St. Thomas's Hospital, with whose series of cases I am familiar, and whose plastic talent is especially great. I have no results of the excision of lupus to show here to-day as I do not do my own surgery. I may mention that a

method of treatment has lately been introduced by Professor Lang, of Vienna, which consists of not only excising the skin but the subcutaneous tissue as well. I have not myself seen the results of that treatment. It appears to me brutal and unnecessary, because the results of excising the skin alone are quite satisfactory in the great majority of cases. Then, of course, there is the familiar method of SCRAPING (or ERASION) which, in a considerable proportion of cases, is followed by excellent results. All that I wish to say about scraping is that I want to show you *an example of how not to treat lupus*.

CASE I.—This patient was under one of my surgical colleagues and he has very kindly allowed me to show her to-day. The condition was very freely scraped in December of last year and extensive skin grafts *at once* applied from the arm. The points of the case very briefly are these. She is 43 years of age; she has had since she was a girl an abscess in the leg, and twelve years ago the lupus started both in the leg and at the same time appeared on the face. The result of treatment is, as you see, a scar thickly studded with lupus nodules. Now, what I consider an infinitely more satisfactory treatment is, in addition to the scraping, to apply immediately afterwards some strong caustic, and I have no hesitation in expressing myself as greatly in favour of the old-fashioned chloride of zinc solution—40 grains to the ounce—well swabbed into the part, and more than once if necessary. The application of the skin grafts should be made after a healthy granulated surface has been obtained. Extraordinarily healthy scars are thereby produced. The healthy granulating wound is generally produced about a fortnight after the erosion.

Incidentally I mention an ointment which is of extreme benefit as a local application in such cases as this now is, namely, what is commonly known as Brooke's ointment; this consists of an ounce of 5 per cent. oleate of mercury, 2 drachms of powdered starch and oxide of zinc, half an ounce of vaseline, 20 grains of salicylic acid and 20 minims of ichthyol. This to be well rubbed into the patch night and morning, and if necessary the ointment may be tinted with Armenian bole and raw umber. If this ointment is applied and covered with some starch powder the cosmetic effect is excellent, and certainly this application, probably owing to its mercurial ingredient, leads to the absorption of a considerable number of nodules.

Now, the other forms of treatment of lupus to which I wish to refer very shortly are those by *tuberculin*, by *X-Rays*, by *Finsen's method* (the light method), but more particularly by thyroid feeding.

The treatment by tuberculin and by X-Rays and Finsen's

method have all, to my mind, to some extent the same mode of action, that is to say, they produce local inflammation of the part with effusion, which, as it were, stifles the bacilli and the toxins which are presumably there as the result of the presence of these bacilli. In fact, it seems to be a sort of process of getting the nodules to "stew in their own juice." All of them are accompanied by great dangers. We know unfortunately too much of these dangers as regards tuberculin. We know how widespread tuberculosis may be set up by it; and I am afraid from what I have seen of the X-Ray treatment that there is possibly some danger in the same direction. Of treatment by tuberculin I shall not show you any cases to-day, because I have not used it for many years, but I should like to express this view of tuberculin, that I still believe, if given over very prolonged periods and in very small quantities, it is of use; for without producing local or general reaction, it does seem capable of producing a certain amount of absorption. I shall not say much about the X-Rays and Finsen's method, because I do not think that we are yet in a position to formulate conclusions about them. I shall, however, show you a case, in passing, of irritation from X-Rays and another case of the same type of lupus as this patient presents, namely, SENILE LUPUS. Such cases are really rather rare, and I am fortunate in being able to show you no less than three to-day. They are absolutely typical cases of lupus vulgaris, exceptional only in the fact of having developed in persons above 50 years of age.

CASE II.—This patient was recently sent to me from Glamorganshire. He is 54 years of age, a miner. There is no history of tuberculosis in his family and there is no indication of how he contracted the disease, whether by inoculation or otherwise. He is a perfectly healthy man in every other respect. The duration of the disease is only two years. It began, as he has told us, with a "pimple" on the left side of his nose, where there is now, you see, a gap with considerable loss of substance. He has been submitted on four successive days to the X-rays, and the result is on the whole gratifying so far. Two days ago, however, after an unfortunately long exposure, he got violent dermatitis of all the parts exposed, with œdema of the eyelids, and his temperature rose to 105.2° . He felt very ill indeed, but has recuperated rapidly. The local effect produced has been, as you see, acute suppuration of and around several of the nodules. I may say that the X-rays in this case were used at a distance of 10 inches under a resistance of 13 volts (which is rather higher than one ought to use), and a current of $2\frac{1}{2}$ milliamperes, while the exposure was for twenty minutes instead of for ten, which is the duration of the period of exposure which all my other cases are having. I have about a dozen cases under the same treatment, but it is so purely in the

experimental stage that I hesitate to bring them before you. There are two points of interest in the case, viz., the rapidity of spread of the lupus over the face, and most remarkable degree of implication of the cervical glands which form a chain of tumours almost as large as pigeons' eggs from one angle of the jaw to the other. In lupus of the senile type this is very exceptional. The patient has been under observation for two years, but I do not know how long the enlarged glands have been noticed; they were not mentioned in the memorandum I received. Some enlargement of lymphatic glands, to a limited extent, is of course common, even the rule, but such a very marked and uniform enlargement of the whole group of submaxillary glands I have never met with before.

CASE III.—By a fortunate coincidence another case of senile lupus in a woman aged 45 was sent to me two days ago by Dr. Stone, of Reigate. She has just come up to the Hospital and no treatment whatever has been adopted. My only reason for bringing this case forward is to show the rarity of senile lupus and the rapidity of extension, although it is only of two years' duration. There is considerable enlargement of the cervical glands, but not comparable to the condition in the last case. There are no symptoms of tuberculosis in other organs, nor any family history, but the diagnosis is perfectly obvious.

The next patient brings us to the question of THYROID TREATMENT. I have had her under observation since the year 1895. It was in that year that I began to treat various forms of tuberculosis of the skin with thyroids. I think that it has been established beyond doubt that thyroids have a beneficial effect in very many of these cases. The preparations I have used all along have been Burroughs and Wellcome's "thyroid tabloids," and recently their "thyroid colloids."

CASE IV.—This patient is now 58 years of age; she was 53 when she came under observation and her lupus began two years before. Previous to my seeing her it had broken down several times and healed up, apparently spontaneously. When I first saw her I noted a great deal of swelling of the whole nose, which was studded with lupic nodules. There was considerable loss of substance of the right ala nasi, and a suppurating gland in front of the right ear. There is no history of tuberculosis in her own family, but her husband died of tuberculosis fourteen years previously to the development of the lupus. After coming under treatment the abscess in front of her ear burst and the scar is visible. I put her on two thyroid tabloids daily and extremely rapid improvement at once ensued. Unfortunately the improvement was interrupted in 1898 by two attacks of lymphangitis of the nose and the right cheek. After these attacks the lupus nodules became acutely inflamed and several fresh ones developed on the right cheek. There was some little difficulty in getting her to "carry" the thyroids, but she has, nevertheless, persevered, and I think the result is very satisfactory. The case, I think, we can almost claim as a cure. It was a very severe one, and if you express the blood from the part, or practise the little manœuvre which Unna terms *diascopy*, you will scarcely find a sign of a nodule anywhere, although at first nodules extended well up to the root of the nose.

If patients are going to improve with thyroids, they generally show manifest signs of doing so within a fortnight. I am very sorry

that two cases which I could claim as positive cures have not been able to come here to-day. One was a boy of 15, who was sent to me in 1896, with what the Germans call a "lupus tumidus." He had an enormous nose, like a tomato, and the case was very acute. The request from his physician was that he should be taken to the hospital and at once operated upon. It so happened that there was no bed available, and I said that he had better have thyroids and come up in a week's time. He came back so remarkably improved that I kept him on as an out-patient, and after three years continuously taking thyroids his recovery was absolutely complete and, as far as one can see, promises to be permanent.

The other case was a butcher lad, aged 18, sent up from the country, who had a sore on his thumb which had been diagnosed as a primary chancre. It was extremely like such, but I was struck by the fact that he had a suppurating gland in the first interosseous space, which was, of course, inconsistent with the syphilitic nature of the thing, and the sequelæ proved that it was certainly not of this character. He got perfectly well in two months with thyroids.

I shall now show you other cases in process of cure under the simple thyroid treatment. Those which I think do best are the acute suppurative tuberculous processes of what is often called the scrofulo-dermatous type, and it is applicable in a large number of cases of lupus where no surgical operation is feasible.

CASE V.—This little boy was brought to me in June, 1896. He is now 10 years of age. He has had lupus on his thigh ever since he was one year old. He had, when I saw him, a large, very hideous ulcerating lupus on the thigh, he also had an ulcerating nodule in the cheek. He was given tabloids and continued taking one daily for a month. Two months afterwards the dose was raised to two tabloids and he has taken these, with occasional short intermissions on account of sickness, ever since that time. The etiology of this case is perfectly obscure. There is no family history of tuberculosis, but he has slightly enlarged cervical glands, which he has had all his life. The patch on the face appears to be an absolute cure and that on the thigh is certainly now approaching it. I may say that absolutely no local treatment beyond occasional zinc ointment or something equally inactive has been employed.

CASE VI.—This is an imperfect case, the reason of which I discovered only yesterday. The boy does not take his tabloids regularly. I was always disappointed in it, and I called at his house and elicited the fact from his mother that he will not take them, and she is not at home during the day to see that he does take them. He is now 10 years of age. He had lupus, which began at the age of 4, on his left wrist and left shin. He came under my observation in 1896, and he rapidly got well in a few months with two tabloids of thyroid daily and, in fact, I discharged him from the hospital. Six months after ceasing the tabloids he

relapsed, and then by some accident he was taken to another department of the hospital for six months without any benefit whatever. He came back to me and resumed the thyroids and the whole thing healed up in ten days. It broke out again in January of this year. I was going to show this as a case of failure, but I must claim it as a partial success. His wrist is completely well. Curiously enough, his brother had lupus in the cheek, which was absolutely and permanently cured by thyroid six years ago.

CASE VII.—This is one of the most remarkable cases I have had. He is not cured, but he is very near it. He is now 28 years of age and came under my observation in 1894. There is no history of family tuberculosis. At the age of 10 he had suppurating glands in his neck and lupus extending from them. When he came to me in May, 1894, he had what I then described as an extremely ulcerative florid lupus of the left side of the neck. It was one of the most hideous lupuses I ever saw. He was treated at once with three thyroid tabloids daily. Within a fortnight remarkable improvement resulted, and this continued under treatment till June, 1898. The local treatment has been Brooke's ointment. The most remarkable changes that occurred were the diminution of the inflammation, the absolute arrest of the ulceration, and the progressive diminution of the number of nodules present. In 1898, that is when he had been taking three tabloids daily for four years, he began to suffer from palpitation of the heart, and discontinued the tabloids for six months, with the result that the lupus patch again became congested and undoubtedly several fresh nodules appeared. He resumed colloids in 1898, and since then has taken tabloids or colloids pretty continuously, and you see the result. He is not by any means cured, but the change produced by the thyroid medication is extremely remarkable. The patient, who was an intensely nervous, hysterical person, through an injury at the base of the skull, has now become quite strong and is getting fat.

CASE VIII.—This is a very similar case to the last. His age is now 15. He has had lupus for the last twelve or thirteen years. He came under my observation in August of last year, and the condition of affairs was extremely similar to that exhibited in the case you have just seen. During last winter he had a violent accidental pus infection which has delayed the progress of the case. It was a peculiarly hideous lupus. It is clearing up rapidly, and I think that we shall have in process of time a state of affairs comparable to that of the patient you have just seen. He has taken the tabloids ever since August last year. He has never had any manifestations of thyroid poisoning whatever. The arrest of the nodules has been pretty extensive. They are becoming isolated, and although they are very, very thick all round the margin, I think we shall probably put him in a condition for operative interference by and by.

One man has not turned up. His age is 71 years. He has had lupus all his life, and I show you the list of the people he has been under. He is a German Jew, and he has travelled a great deal. His assertion is that nothing ever did him good before. He has a very extensive chronic lupus, and is not at all a favourable case for thyroid treatment. However, the treatment has had a most extraordinary effect upon him for it has stopped the spreading. He was very susceptible to thyroid poisoning, and one could only give

him half a tabloid. He told me that he had suffered all his life during winter with these acute ulcerative outbreaks, which are so common in lupus during that season of the year. All the winters he was under my care his lupus remained absolutely quiescent. At the present moment he is undergoing Finsen's light treatment under Dr. Stephen Mackenzie, at the London Hospital.

I shall now show you two or three cases which have been treated by thyroids and surgery.

CASE IX.—The patient before you is now 23. She has had lumps in the neck ever since the age of 7. In 1895 typical lupus developed on the nose and on the cheeks. She had a few scrofulous glands excised at Margate in 1896, and she came under my observation in November of that year, when she had enormous cervical glands. My friend and colleague, Mr. Pearce Gould, excised these from ear to ear. Her lupus was really very extensive, and it is difficult to believe that it was so. I scraped her and used the galvano-cautery. Since then she has been constantly on thyroid feeding, and once or twice I have scraped away scattered minute nodules. She carries her thyroids very badly, and very often has to reduce them to one a day or to discontinue them altogether, because she gets fainting fits. The colloids suit her better than tabloids. I think the result is a very good one. I should like you to notice how perfect the results of Mr. Gould's operations are, and I think the result of my own operation is not bad. Certainly the tendency to reproduction of lupus is checked by thyroid feeding. When the patient stops the thyroids she generally gets some slight recurrence of lupus.

The next cases I am going to show you are not so striking as the others which I have demonstrated. Still it is only fair to show one's partial, as well as one's more complete successes.

CASE X.—This was looked upon as a great success at one time, but he has the liability to relapse. He is now 22 years of age. He came under my observation in 1892 with a patch of lupus of the ear, dating since the age of 6 months. He had been treated by medicine and ointment, and was told that "he would grow out" of the disease at 14 or 15. It is a very curious thing that that statement is very frequently made. He had when I first saw him a very florid ulcerating lupus. He was then scraped and treated by pyrogallic ointment. In 1895 he was put upon thyroid tabloids, three daily, and was discharged "cured," according to my notes, in two months. He relapsed very soon afterwards and continued the thyroids for six or seven months, and again recovered perfectly and kept quite well till July, 1899. He came back to the Hospital in January in this year, since when he has been taking three thyroid tabloids daily. The ulcer is now drying up, and I think he is going to get nearly as well as he was when I noted him as cured. There is a very strong consumptive history in his family; his mother, six aunts, his maternal grandmother and grandfather all died of phthisis.

CASE XI.—The lady before you has very much the same history as the case which I have just shown you, that is to say, she recovers and relapses. She is now 34 years of age. She came under my observation in March, 1896, with severe ulcerative lupus of the nose. She was at once put on thyroids, which she takes rather badly. In December, 1896, Dr. Lewis of Chelmsford, who sent her up to me, reported her as *perfectly cured*. However, she unfortunately relapsed, and in

1897 I took her into the hospital and scraped her. She has taken thyroid either in the form of colloids or tabloids, one to three daily, with occasional interruptions owing to sickness, headache and rapidity of pulse. This I cannot claim as exactly a success, but she is a very great deal better than she was when she first came to me. As you can observe, a good deal of partial recovery has taken place here and there, but the result is not one I would say very much about. She had some swelling of the nose at her first visit and that is much diminished.

CASE XII.—The next case is a very similar one. It is one of those cases which fluctuates extremely. Whenever she takes thyroid she gets extraordinarily well, whenever she ceases she relapses pretty acutely. She is not able to come up to the hospital regularly, so that she cannot take the thyroid continuously. The history of this case is as follows:—She has been under my observation since June, 1894. She had Koch's treatment when that was in vogue and she improved. She has been intermittently under thyroid feeding ever since, always benefiting when taking the tabloids, always relapsing acutely when not.

This poor woman had very severe lupus indeed when I saw her in 1894. She always has a tendency to ulcerative lesions in the winter, and I think the condition is worse to-day than I have seen it for a great many years; but looking back upon the state in which she was when first put upon the treatment the condition is fairly satisfactory to me, as it is to herself. I think that this is a case where the combination of surgery with the thyroid would be beneficial, but she has active employment and cannot avail herself of such treatment.

CASE XIII.—The next case, a little girl, is the last that I am going to show you on this occasion. I have brought her not so much on account of thyroid treatment, because she has only had it a week or two, but to show you a slightly unusual phase of lupus, which has been called by Mr. Hutchinson "lupus psoriasis," by which we mean a patch of lupus which presents superficial resemblances to psoriasis both in position and with regard to its scaliness. I do not know what the effect of the thyroid treatment will be upon this patient. When I saw her first, a month ago, she had an acute, rapidly breaking down lupus on her back, which as we see now is improving.

One word as to my idea about thyroid treatment. I think it is an extremely valuable adjunct in the treatment of lupus vulgaris, where excision or erasion of the part is not applicable. I think that it presents certain advantages over the tuberculin treatment, the X-Ray treatment and possibly the light treatment. In my opinion, it is less dangerous on the whole, and I think that the dangers of thyroidism have been somewhat exaggerated. We well know that it was greatly in vogue for psoriasis, where it is perfectly useless. I have already mentioned the cases which are most suitable for this form of treatment. I think it may even be of use in the most chronic cases of lupus vulgaris, as preventing the spread of the disease, and as preventing these ulcerative attacks which so frequently occur at certain seasons of the year, more especially in cold weather, and I think finally that it may be a very useful adjunct to surgical treatment as preventing relapse.

THE "CACODYLIC MEDICATION."

BY WM. EWART, M.D.CANTAB., F.R.C.P.

GENTLEMEN,—Although I have a good supply of clinical cases to show you, therapeutics will be rather prominent in my remarks to-day which will illustrate not only the action of some medicinal agents, the preparations of cacodyl, but other methods also, viz., the mechanical treatment of emphysema, the mechanical treatment of empyema, a demonstration of which was omitted at our last meeting, and the technique of the saline infusion and of the gelatine injections. In connection with all these I shall endeavour to make my remarks practical and to illustrate the methods by demonstration.

THE "CACODYLIC MEDICATION."

We owe to French physicians this important addition to therapeutics. During the last two years the method has had a sufficient trial to have earned for it a place in our prescribing list; but it is hardly known even to dispensing chemists in this country, and there is still some difficulty in obtaining the remedy.¹

We are all familiar with the remarkable powers which belong to arsenic as an antiseptic, as a nerve tonic, and as an agent favouring metabolism. Any increased facilities for its administration must be therefore regarded as a welcome development rather than as strictly speaking an innovation. The novelty consists in the extraordinary extent of the advance which has been made. We can now administer arsenic in quantities previously unheard of, and without the misgivings and risks which have hitherto limited its use.

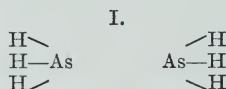
Arsenic, long prescribed for the most varied conditions because of the obviousness of its beneficial effects, is thus likely to be given

¹ It may be procured from Gilbert Kimpton & Co., 19, St. Dunstan's Hill, London, E.C.

wider opportunities. A remedy which in relatively small doses can benefit or cure such intractable diseases as pernicious anæmia and chorea, might in larger doses take considerable effect in many affections, including those previously treated by arsenic, the variety of which is so great because arsenic influences nutrition. Reports from abroad and from those who like myself have used the drug in this country confirm this tale of beneficial results; though none can tell at this stage how far large and long-continued doses may be free from disadvantages at a later date.

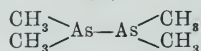
The Constitution and Properties of Sodium Cacodylate.

The characteristic peculiarities of the salt at present in use, sodium cacodylate, viz., its *great solubility*, its *relative freedom from irritating and poisonous properties*, and the high charge of arsenic (46·86 per cent. by weight) which it contains are the outcome of its chemical constitution. The metal is incorporated into an *organic molecule*, as shown in the following suggestive formulæ.



Two molecules of arseniuretted hydrogen.

- II.

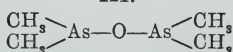


One molecule of cacodyle, or dimethyl arsenide.

Starting from arseniuretted hydrogen which reminds us of the molecule of ammonia (NH_3), we obtain by substituting methyl for hydrogen, a dimethyl arsenide which is cacodyle, a fluid frightfully unpleasant to smell and highly poisonous. The introduction of oxygen to form the oxide of cacodyle does not remove these objectionable features.

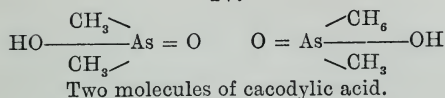
But the next step, the oxidation into cacodylic acid, is identified with a complete change in the chemical constitution, in the chemical features, and in the physiological properties. The metal, hitherto a triad, passes into the pentad stage, and as sodium cacodylate it loses its virulence and its smell.

III.



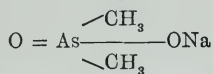
One molecule of oxide of cacodyle.

IV.



The *sodium cacodylate* of which I now show you a specimen, is

V.



One molecule of sodium cacodylate.

a highly soluble, deliquescent solid, free from smell and from taste, non-irritating, except in concentrated solutions which, when injected subcutaneously, though not painful at the time, are liable to set up locally subacute inflammatory swellings.

Its diluted solutions are well tolerated by the stomach, even when prescribed, as I usually prescribe it, to be taken at a distance from the meals. Pills cannot be prepared by the ordinary methods, for it is so hygroscopic, but they are supplied from Paris.

Thus the formation of the reduction products, viz., the oxide of cacodyle and cacodyle itself, is to be avoided, although their liberation on a small scale seems to be inseparable from the ordinary mode of administration by the mouth, their characteristic garlic smell being always evolved in the breath.

Perhaps as in the "haptophore" theory of Ehrlich¹ for toxins there may be a partial unlinking of the affinities, and a differentiation into a toxic arsenical element and into one which is not toxic. The pentad state may be partly resolved into the triad state. At any rate it is clear that whilst, owing to its high degree of solubility which allows its free absorption and diffusion throughout the economy, it has every opportunity of acting upon the tissues, its action is of an attenuated order and does not bear the usual toxic proportion to the actual weight of metal introduced.

The Mode of Administration and the Dose.

Three methods have been in common use, the ingestive, the rectal, and the hypodermic. The rectal method which is convenient enough with bedridden patients, because the bulk of the injection

¹ Cf. *British Medical Journal*, April 14, 1900, p. 917.

is very small (a drachm or two), has the advantage in my experience of not spoiling the breath. Absolute freedom from the smell of garlic is a special feature of the hypodermic method.

(1) *By the mouth* the half grain pills, which I pass round, are a convenient preparation. Three or four daily may be taken by an adult as an initial dose, which may be increased; or the equivalent may be given in solution, and in this form the dose may be easily adapted to smaller requirements, as in children, &c. The time of administration, particularly at first, may be at meals; but I have usually selected the intervals between meals.

(2) *The rectal method* has been much advocated abroad as safer than administration by the mouth because less liable to give rise to the reduction products. The dose may be started at half a grain in the adult and increased. In children with chorea I have begun with one third of a grain. As little as half a drachm of water may be used as the vehicle, but perhaps more conveniently one drachm or up to four drachms.

(3) *Hypodermically*, one third of a grain in ten minims of water is a fair initial dose and may be increased to one grain or more. This is the most scientific method. We avoid the unknown complications arising from the innumerable chemical reactions which take place down the alimentary tract. We know, moreover, that the drug is distributed all over the body before having passed through the liver. For these reasons I have resorted to the subcutaneous injection in the more important cases in which the full powers of the drug had to be brought out, as in pernicious anæmia, Graves's disease, &c.

The maximum dose is a question still to be solved. Results obtained well within the margin of that maximum leave me satisfied not to push matters to extremes, particularly if the treatment is to be continued.

(To be continued.)

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY DR. GUTHRIE RANKIN.

July 25, 1900.

GENTLEMEN,—I desire in the first place to ask your attention to this patient, who you may remember seeing here about a month ago. He was brought to Dr. Payne on account of a pronounced granulomatous eruption confined to his face, which was suspected and has since proved to be, due to iodide of potassium. The eruption has now, as you will observe, almost wholly disappeared; the curious feature about the case was that whereas the man had on this occasion only taken iodide in 10-grain doses thrice daily for a little over a fortnight, he had been some months previously under continuous treatment by similar doses over a period of many weeks without the slightest evidence of iodism. A suggestion was made when the man was last here that the explanation might be found in a new purchase of iodide of potassium having been made by the hospital between the times of his first and second residences, but I have enquired and find that the same stock of the drug was in use on both occasions. The patient is, apart from this sudden and unaccountable susceptibility to iodide, an interesting example of parasyphilitic phenomena. There is a clear history of specific infection fifteen or sixteen years ago, and he now suffers from undoubted locomotor ataxia together with advanced aortic disease of—as far as can be ascertained—some years' duration. All the classical features of tabes are present, as you see, and he has a double murmur in his aortic area, with ample evidence of widespread arterial degeneration. He has never suffered from rheumatic fever.

Within the last year he has developed a certain hebetude of appearance and drawling utterance, together with muscular tremors which, as you observe when I ask him to rise, are clearly of the intentional type. This new addition to his previous symptoms is extremely interesting, and though the explanation is not yet clear it suggests cortical changes which will probably prove to be associated with cerebral degeneration such as occurs in general paralysis.

Dr. Mott, in his Croonian Lectures, has within the past few weeks been bringing vividly before us the close relationship which exists, in cases of degeneration of the neuron, between locomotor ataxia and general paralysis—so close that he is disposed to look upon the two diseases as mere varieties in distribution of the same pathological departure from health. This case is a valuable witness to the probable correctness of the view Dr. Mott holds, and also to the generally accepted fact of the important etiological influence of syphilis in degenerative diseases of the central nervous system.

I next ask you to look with me at a case of amyotrophic lateral sclerosis, which has been kindly sent up by my colleague, Dr. Hewlett. As you know, this condition, which was looked upon by Charcot and described by him as a disease *per se*, is now considered by most authorities to be neither more nor less than a variety of progressive muscular atrophy. Most text-book descriptions of progressive muscular atrophy recognise three varieties, which may be classified either on a clinical or pathological basis; one in which the disease is entirely or mostly limited to the great cells of the anterior horns, and is characterised clinically by progressive wasting and fibrillation of one set of muscles after another; second in which the morbid process has spread from the anterior horns to the lateral columns and in which the clinical picture of spreading atrophy is further elaborated by the addition of spastic phenomena beginning in the legs; and yet a third, in which pathological extension has taken place, not only laterally but upwards as well, so that the medulla has become invaded in centres corresponding to the anterior horn cells of the cord, and again the clinical features of the condition are altered by the addition to the previous symptoms of those indicative of bulbar paralysis. The case before us is a typical example of the second of these varieties, and may not unlikely, at a future date, require to be classed under the third. The man is a stoker, aged 28, and the present condition commenced some months ago with, as is usual in such cases, wasting of the muscles of the right thumb. It is interesting to speculate how far the stress put upon the right arm of a hard working man may be responsible for the distribution of a degenerative process of this kind. The disease, it is true, generally starts in the cervical enlargement of the cord, but why should the right hand suffer so much more frequently

before and in greater degree than the left, unless it be that from more continuous use, the horn cells which are responsible for its physiological integrity, become sooner exhausted and therefore more susceptible to toxæmic or other noxious influence? This man tells us that before he observed any of the wasting which is now so striking, he was conscious of a loss of power in the right hand and of a certain clumsiness in the use of his fingers, to which he had not previously been accustomed. This is the usual history; the loss of power and the atrophy no doubt take place simultaneously, but the weakness appeals to the patient's consciousness in his every day work and arrests his attention often long before he observes that the shape of his hand is changing. Gradually this wasting process has spread from one group of muscles to another, and on examining his shoulder you will see that the deltoid and spinati muscles are less than half their normal size and that there is clear evidence of diminished vigour in such other muscles as the serratus magnus and pectoralis major. The left upper extremity is also involved, though in a less degree than the right, but the rate of progress has, from the notes of the case, been ominously rapid. The fibrillary tremor of the affected muscles is very clearly brought out when I ask him to endeavour to raise his right arm above his head. Passing now to the legs, you will observe that, up till now, they have escaped the wasting process, but there is a certain degree of spasticity noticeable both in his gait and when I attempt to flex and extend his leg at the knee. The knee-jerks are exceedingly active, ankle-clonus is well marked, and the toe phenomena are extensor on both sides. There is no impairment of sensation, the sphincters are normal, and the man has no complaint to make of his general health. The wrist-jerks, you will observe, are increased, but though often found in such cases, no chin-reflex can be elicited. I understand from Dr. Hewlett that the treatment being carried out consists of abundant feeding, gentle massage, faradisation, and the subcutaneous injection of strychnine; but so far there is no evidence that the progress of the disease has been arrested.

Our next patient is a man who is under my care at the Dreadnought Hospital, and who is suffering from an aneurism of the ascending arch of his aorta. As he exposes his chest you can all, even at some distance, see the pulsation of the enlarged vessel to

the right of the sternum in the second and third interspaces, and those of you who care to examine his chest more carefully will readily make out a systolic thrill and the usual diastolic shock so characteristic of these cases. He has had nothing to complain of so far except pain, and that has subsided very considerably under the influence of rest in bed and iodide of potassium. My chief reason for bringing him before you is that you may examine him now in order to compare his present condition with that he presents when I bring him again under your notice, as I hope you will allow me to do a few months hence. He is at the commencement of a course of treatment by subcutaneous injections of gelatine, according to the method approved and advocated by Lancereaux, and it may be a matter of interest for you to see what effect the treatment has in a case so pronounced as this one is. He has already had one injection delivered on the inner side of his thigh, and, beyond a passing slight pyrexia of a few hours' duration, he has suffered no inconvenience from it.

I now bring before you a case which is not of special interest, except for the evidence of disease afforded by the patient's eyes. She came first to me on account of severe migraine of many months' duration. Under treatment this improved materially, and she left off her attendance at Waterloo Road; but some months later she contracted influenza, and after her recovery she observed a certain dimness of vision, which increased rapidly and became so pronounced that she could not see to thread a needle. She consulted her doctor at home, and he at once recognised, on examining her fundi, the presence of hæmorrhages, and advised her to come back to hospital. A few days elapsed before she could do this, and meantime she developed headache, sickness, shortness of breath, and œdema. We took her in at Waterloo Road and found all the usual evidences of chronic Bright's disease. She has improved very considerably, and is now able to go about her ordinary duties as usual, but her present condition may be interesting to you as illustrating three very important clinical points about such kidney conditions, viz., a very high-tension pulse, marked accentuation of the sound over the aortic area, and one of the most beautiful examples of albuminuric retinitis you are ever likely to see. It is interesting to hear from Mrs. Pringle that her sight now gives her no trouble, and that

though she has an occasional headache, there has been absolutely no return of the old migraine. How far it was a prelude to, or may have been dependent upon, the same cause as the nephritis, I submit to you as an interesting problem.

The next two cases are both examples of fibroid degeneration affecting the left lung, and they exemplify what I believe to be similar physical conditions dependent upon different causes. Fortunately, they are also interesting as supplementary to the cases of cardiac displacement demonstrated last week by Dr. Squire, as in both the patients before you the heart has become dragged from its normal situation by retraction of the lung. In the girl's case the disease is of many years' standing and, as you see, the whole left chest is immobile, flat, and dull to percussion. She has occasional "colds" accompanied by cough, but is as well to-day in her general health as she was ten years ago and recently has been putting on flesh. The displacement of the heart is so great that the apparent apex can be felt and seen beating in the sixth interspace behind, between the spine and the scapula. Immediately above the situation of this pulsation there are all the physical evidences of a limited cavity which is undoubtedly bronchiectatic in character. The sputum has been examined again and again, but the bacillus of tubercle has never been found. So far as can be ascertained from the history, the beginning of the illness was probably a pleurisy, and the girl is, I think, an excellent example of that simple form of cirrhosis of the lung to which attention was first called by the late Sir Andrew Clark. The other case resembles this one very closely so far as the appearance of the chest is concerned. You will observe the same flatness, dullness of percussion, and immobility over the left side; the heart is likewise displaced, but here you will find the displacement is mostly upwards, so that the apparent apex-beat is behind the fourth rib, and there is pulsation in the second and third left interspaces—probably explained by retraction of the shrunken lung. When the man first came to the hospital there was some suspicion that the condition might be one due to aneurism of the arch occluding the bronchus and so causing collapse of the lung, but though there is a systolic murmur over the pulmonary area this is probably the result of traction, and there is an entire absence of pain, pressure symptoms, or the other ordinary phenomena of aneur-

ism. The man has but recently come under observation, and only one examination of his sputum has so far been made and that with negative results. But on listening to his chest you will hear moist rales abundantly between the scapula and the spine on the left side; you will also agree with me that there is some impairment—though so far it is indefinite—of the respiratory murmur over the right upper lobe. The man, moreover, has a slight increase of temperature, and he has not been wholly without cough for a very long time. Being a foreigner, it is difficult to ascertain the precise time since he first became ill, but the condition of the lung itself is enough to make us certain that it is not an affair of yesterday. Now, here is a case where in all probability the cirrhosis is secondary to, or at any rate associated with, tuberculosis; a very different condition from that of the girl we have just looked at, and one, I venture to think, in which the prognosis wears a very much more serious aspect. We have but to look at the two patients, apart altogether from any examination of their chests, to be at once convinced that the man is suffering from some form of serious and debilitating disease, whereas the girl, as she stands before us, if she has anything at all the matter with her, has all the outward appearance of vigorous health.

Finally, Gentlemen, I have been fortunate enough to be able to collect a series of cases illustrative of some of the varieties of heart murmur, and combinations thereof, with which we are all more or less familiar. I have had them seated in the neighbouring room where you can examine them at your leisure, compare the varieties of murmur one with another, and correct any errors of mine in regard to what I believe to be the diagnosis in each case. No. 1 is an example of mitral regurgitation occurring in a chlorotic girl with a history of rheumatic fever. There are also characteristic hæmic murmurs over the base of the heart and in the vessels of the neck. No. 2, though not a case of true aortic stenosis, presents a well-marked systolic murmur in the aortic area. No. 3 is a typical case of double aortic disease. No. 4 has, in addition to an ordinary double aortic murmur, a præ systolic bruit and thrill in the mitral area; and No. 5 is an unmistakeable case of double valvular murmur heard both in the aortic and mitral areas from disease affecting both the orifices of the left ventricle.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. JONATHAN HUTCHINSON.

(Continued from page 43.)

XX.

I FEEL sure that many present will remember the case of a young maid-servant who was brought to us some months ago on account of sores on her genitals. She was an anæmic girl, evidently much out of health. A diagnosis of venereal sores had been suggested, and the surgeon who had examined her, as well as her mistress, came with her. The girl's character was at stake, and the diagnosis for her was a most important one. On examining her we found the nymphæ inflamed and swollen, and on the inner aspect of each was a group of sores covered with gray secretion almost pellicular in character. These sores appeared to be made up by the coalescence of several, and above and below the principal patches there were small ones which did not join them. The mode of grouping suggested to me the diagnosis of herpes, and this was my final diagnosis. It was given, however, with a little hesitation for the inflammation was much in excess of anything which I have ever seen in herpes of the genitals, and besides, the conditions were accurately bilateral. Still, the history of sudden onset, the absence of buboes, and the general appearance of the sores, taken together, made me venture an opinion which exonerated the girl from the suspicion of misconduct. Her extreme pallor and aspect of ill-health, with the history that she had been feeling ill and shivering, helped me not a little.

I have taken some trouble since this patient was with us in order to ascertain the sequel of her malady. She became afterwards the inmate of a poor-law infirmary, where I believe there was still some difference of opinion as to the diagnosis. I am informed, however, by a gentleman who kindly replied to my letter, but requested me

not to mention his name, that nothing indicative of syphilis was ever observed. The sores healed after some time under simple treatment, and the girl regained her health to a considerable extent. Tonics were given and no specifics were used. I think, therefore, we may take it as established that the sores were herpetic and not in any sense venereal.

It may be worth while to say a word or two respecting herpes of the genitals in women. I suspect that it is a condition which none of us see often. Women are reluctant to ask advice which they know will not be given without inspection of the parts, and as herpes is transitory, they usually allow it to run its course. I do not know how it may be in family practice, and I have forgotten how it used to be in the out-patients' room, but speaking from private consultations I may say that I do not examine a woman with herpes once a year. Men, on the other hand, constantly mistake herpes for venereal sores, and rush off at once to the surgeon. I see a great many cases of herpes preputialis. There is a good portrait of herpes on the female labia in Hebra's Atlas, but it is the only one with which I am acquainted. Thus, then, one may be excused for not being very familiar with the aspect of herpes on these parts in women. The case which I have recalled to your notice was of extreme severity and unusual in its extent as well as in being bilateral. It is seldom that what we know as "symptomatic herpes," that is, herpes of the orifices of the body, is symmetrical; it is, however, occasionally so. I have seen it on both sides of the mouth repeatedly. It is needless for me to insist upon the importance of being alive to the diagnosis under discussion, for few errors are more to be deplored than those which needlessly impute unchastity in women.

XXI.

Amongst the cases which have interested us most during the last year is that of a married woman, whom through the kindness of Mr. Hichens we have twice seen. The chief feature in her case is the formation of large irregular plates in the subcutaneous tissue which assume a bone-like hardness. She has a large one on the front and outer side of her left thigh and another on the hip a little higher up. These are as large as an outspread hand or even larger.

They commence by induration and swelling which involves the skin as well as the tissues under it, and then rather quickly contraction ensues and the whole patch is depressed and almost like a scar. The induration finally resulting is extreme, and on the occasion of our last seeing Mr. Hichens' patient there were bands so hard that it was impossible to feel sure that they were not bone. On this occasion a new phenomenon had been developed, and there were a number of little accretions of a white substance in the scars which looked much like tophi. A white substance could be picked out of these much like mortar, but Captain Pinch reported to us after chemical examination that it was fatty and not urate of soda. I was very much interested in these pseudo-tophi, for I had formerly expressed an opinion that the condition was in direct connection with inherited gout. Mr. Hichens' patient is a fair complexioned rather florid woman and she gives a history of true gout in a near relative.

We may suspect that these patches are in some way related to those of herpetiform morphœa, but at the same time they are very different. I will briefly mention to you the cases which in my memory most closely resemble our patient.

The first example of it which I ever saw was in an elderly man whom I saw at the suggestion of the late Dr. Peacock. He was the subject of gout and subsequently died of gouty kidney. In him there was a very large area of induration over one buttock, parts of which were like bone in hardness. There were also concretions like tophi in it.

In a second case in which so far as I remember there was no known gout, numbers of indurated plates formed under the skin during a very prolonged illness with high temperatures. The induration was never extreme, and the patches disappeared after a time leaving depressions (subcutaneous scars.) A full account of this case is given in my "Archives."

In a third case I have several times produced the patient at our demonstrations. She is a stout woman, and ten years ago her face afforded the subject for Plate 72 in my lesser Atlas. The whole of one cheek had indurated and subsequently ulcerated almost like a large very chronic carbuncle. There was no history of syphilis, but the parts healed under mercurial treatment. Now three or

four years later this woman had huge areas of subcutaneous induration on her shoulders. They were almost symmetrical and as large as dinner-plates. They did not incommode her and she did not care for treatment. I do not know her present state.

Canaliculi patent
In a fourth case which I have seen quite recently, a very stout *bon vivant* man is now the subject of rheumatic gout with nervous symptoms of very obscure kind. He has on various parts indurations of the subcutaneous structures, which persist for a few months and then disappear. They are not so large nor nearly so hard as those in some of my other cases, but they are, I feel sure, of the same nature. (See *Archives* for April, 1900, p. 175).

REVIEWS AND NOTICES OF BOOKS.

A PICTORIAL ATLAS OF SKIN DISEASES AND SYPHILITIC AFFECTIONS FROM MODELS IN THE MUSEUM OF THE ST. LOUIS HOSPITAL, PARIS. Pp. 302. Rebman Publishing Co.

THE magnificent collection of portraits of skin diseases which, under the editorship of Dr. Pringle, has recently been published by Messrs. Rebman, presents unrivalled attractions in several important features. It consists of a reproduction by chromo-lithography of a selection from the models in the museum of the St. Louis Hospital in Paris. That museum has a world-wide reputation, and the excellence of M. Barretta's work as an artist has never been surpassed. Not only, however, has the modelling been finished with extreme accuracy and beauty, but the cases which formed its subjects have been studied under the greatest advantages as regards modern dermatological knowledge. It is no mere collection of models with bare names attached, for in the majority of instances the case history in great detail and from the pen of a master is appended. Thus a visit to this museum has all the advantages of a visit to a hospital. You can study the patients, and often not only at one stage of the complaint, but at several, and you can obtain with a minimum of trouble a carefully sifted history of most of the cases.

In the Atlas which Dr. Pringle has edited and of which one volume (we sincerely hope only an instalment) is now complete, all these advantages have been reproduced. The plates almost equal the original models, and the letterpress is from the pens of the hospital physicians, each describing a case which had specially interested himself. Thus we have case narratives in some instances extending even to little monographs from such men as Besnier, Fournier, Hallopeau, the much-lamented Feulard, Thibierge, Darier, Sabouraud, Tenneson, and Jacquet. The work is one which no dermatologist can dispense with and which to general physicians and pathologists affords the best possible insight into some of the most difficult problems of dermatology. These problems are no longer matters merely of specialist interest, but are of the utmost importance in various directions in their bearings upon pathogenesis in its widest sense. Such subjects as tuberculosis of the skin, leprosy and granuloma fungoides, to say nothing of syphilis, do not belong to the dermatologist, but to all who are engaged in the study of disease, whether in its medical or surgical aspects. It is in this sense that we specially commend this Atlas. It is clinical in the best sense of the word, and is adapted to the needs of all patient students whether specialists or not. In addition to the descriptions given by the French authors whom we have named and which constitute, of course, by far the principal part, the letterpress receives great additional value by the insertion of judicious notes by the Editor, Dr. Pringle.

We shall have occasion in the future to refer frequently to the pages of this Atlas, and will not on the present occasion mention any subjects in detail. We have only to add that it is published at a very moderate price and to repeat the hope that other volumes of it will follow.

NOTES FROM THE CONGRESSES.

During the last month two important Medical Congresses have been held, that of the British Medical Association at Ipswich, and the Triennial International in Paris. The following notes relate only to a few selected topics, and have been based upon the full and excellent records which have been published in our contemporaries, the *Lancet* and *British Medical Journal*.

Venereal Disease in the Army.

In the Section of State Medicine at Paris, Colonel J. Lane Notter, of Dublin, Congress delegate from the War Office, read a very important report on the present prevalence of venereal disease in the British army. As regards home stations, he showed that although at the protected stations a slight increase had followed the repeal of the Contagious Diseases Acts in 1886 (after twenty years of force), it was only in continuation of what had been going on before the repeal and that it had since been substituted by a steady decline. This decline was shared alike by the stations which had been protected and those which had not, and it appeared to be still progressive. It was attributable, Colonel Notter thought, to the improved education both of soldiers and prostitutes. This had resulted not only in greater self-respect and care as to health in the woman, but in the diminution of drunkenness, the development of other tastes, and increased self-restraint in the man. That an army surgeon should be able to say this, recording his belief that the improvement will continue, to add that "no regulations can with reason be recommended," is indeed cause for satisfaction. As regards the army in India, his report was not so good, but it was believed that the Cantonment Act of 1897 was working well. In Gibraltar, where no enactments are in force, the prevalence of disease is great, though not so high as in India, whilst in Malta, where the acts have remained in force, it is low. The sources of fallacy in these statistics are so numerous that we may well hesitate in giving full acceptance to the lessons which they appear to teach. It is, however, most gratifying to know that they have so impressed Colonel Notter that he is able to recommend the very lenient Cantonment Acts of India for Gibraltar and their substitution at

Malta for the far more stringent ones in force, whilst at home he is prepared to rely wholly upon the education of the soldier in reference to the disease, the encouragement of physical and intellectual amusements and the inculcation of self-restraint.¹

"Menière's Symptoms" or "Menière's Disease."

Dr. Moll, of Arnheim, described the very various conditions which might produce the group of symptoms to which Menière's name is attached, and urged that we ought not any longer to speak of Menière's disease as if it were an entity. This interests us because it is what we have long been urging. Such expressions as "Menière's disease," "Raynaud's disease," ought certainly to be substituted by Raynaud's phenomena and Menière's symptoms.

The Microscope in the Diagnosis of Cancer.

A discussion on the diagnosis of cancer of the larynx gave occasion for the expression of important opinions as to the value of the evidence given by the microscope. Even those who claimed, what probably all will grant, that there are conditions about which there can be no mistake, were fain to admit that such conditions as globular masses of epithelium—the time-honoured "nests"—and even the continuous down-growth of epithelial processes, were delusive, inasmuch as they might attend non-malignant disease. Sir Felix Semon and Dr. Mermod both deprecated reliance on the microscope and advised the careful study of the clinical evidence. Dr. Krauss, of Paris, and with him Rualt of Paris, and Bar of Nice, went so far as to say that they thought it wrong to attach much importance to the results of the microscopic examination of cancer of the larynx, inasmuch as such examination gave no clue to the clinical type of the growth. Dr. Bar added that tuberculosis and cancerous disease might co-exist.

"Generalised Gonorrhœa."

It would appear that we are henceforth to admit such expressions as "generalised gonorrhœa" and "gonorrhœal generalisation." Under them are to be included the joint-affections which constitute gonorrhœal rheumatism and the iritis and the muscular and fascial pains which sometimes accompany it. As to whether such affec-

¹ *Lancet* Report, August 18, p. 540.

tions are due to the absorption into the blood of the gonococcus itself or of its toxin (gonotoxin) there is still much doubt. An important discussion on this subject received valuable contributions from Prof. Lesser, of Berlin, Dr. Balzer, of Paris, and others. Lesser fully admitted the existence of predisposition on the part of the patient, inasmuch as some patients manifest these results in connection with any gonorrhœa they catch. In English practice we believe that this predisposition is almost invariably inheritance from gouty ancestors. Dr. Balzer remarked that the gonococcus itself had been many times demonstrated not only in the vessel walls but in the blood itself, and he believed that its toxin was also capable of producing many of the generalised effects of gonorrhœa. He thought that the more extensive the local disease the greater was the risk of generalisation, and that previously damaged tissues were more prone to show the results of generalisation than others. He was willing to admit that the action of the parasite or its toxin might not be direct, but through the nervous system. There may be room for doubt as to some of these points. Certainly in English practice some of the most severe forms of gonorrhœal rheumatism have been initiated by very mild gonorrhœas, so mild in some instances as to be almost doubtful. Also they have sometimes followed a gonorrhœa which had long ago lapsed into a slight gleet. It would appear that in such cases the patient's predisposition, and possibly some other conditions, take a large share in the causation. Mr. Clement Lucas's important observation that synovitis in infants not infrequently follows purulent ophthalmia, must not be lost sight of, since it enables us to put aside the suggestion that generalised gonorrhœa is connected in any special manner with the urethra. Some of the speakers in the discussion appeared to even attach importance to the special part of the urethra affected.

Tuberculides of the Skin.

The various manifestations of tuberculosis which are observed as diseases of the skin were the subject of a discussion in which Dr. Colcott Fox, Dr. Cæsar Boeck, Prof. Campana, and Dr. Darier took part. Our non-specialist readers may perhaps need to be informed that a distinction is now drawn between a "tuberculous affection of the skin" and a "tuberculide." There is as yet much

that is doubtful as to the real relationships of the two and the modes of distinguishing between them. Roughly speaking, however, it may be said that the tuberculous affections are often local and very rarely indeed symmetrical, and that the actual presence of the bacillus may usually be proved. The tuberculides, on the other hand, are often general and symmetrical, and the presence of the bacillus can seldom be proved either by the microscope or by inoculation experiments. Yet, in spite of this failure of proof, there are certain facts connecting these affections with tuberculosis which are satisfactory to most of those who have patiently studied the subject. The questions concerned are of extreme interest, and for present use the term tuberculide may be found convenient, with the proviso that it is not to be accepted as implying more definite knowledge than we really possess. The theory of toxins is, of course, ready to our hand, and it may and indeed has been suggested that the tuberculous affections are due to the bacillus itself, and the tuberculides to its toxin. These toxin-hypotheses are, however, so perilously easy of suggestion, and at the same time so difficult of proof, that a certain degree of scepticism is naturally excited. They may, nevertheless, be true, and whether literally true or not they probably convey a correct impression of the facts. In these cases there is some infective material present which owes its origin to tuberculosis and which may probably be carried by the blood. When, however, some theorists on this subject ask us to believe that they exert their influence not directly upon the skin but upon the vaso-motor nerve centres, they take us into a further domain of easy speculation and yet more difficult proof. It is one also which we think will be found when the facts are carefully sifted to be opposed to probability.

In the discussion referred to Dr. Boeck insisted, perhaps more strongly than is consistent with facts, upon the symmetry of the tuberculides as a distinctive feature. Dr. Darier laid much less stress on this. Professor Campana did not think it possible to distinguish between the two, and made some interesting comments on the well-known fact that the tubercular bacillus does not flourish well in the substance of the skin, explaining it by reference to the small amount of oxygen which the skin contains, the bacillus being unable to live an anerobic life. At first sight this suggestion sounds a little at variance with the modern doctrines as to the treatment of

pulmonary phthisis according to which free exposure to oxygen is of the first importance in order to kill the bacillus. No doubt, however, the two positions are susceptible of easy reconciliation. Campana admitted that a general intoxication with tuberculous products might be the predisposing cause of certain cutaneous manifestations. Dr. Darier entered into much detail and enumerated the various affections which might, he thought, be classed as tuberculides. He very properly insisted that even when present the tubercle bacillus was not easy of detection, and that great care and patience were required in order to give force to a negative conclusion. He admitted, however, that respecting the tuberculides, with hardly an exception, neither bacteriological examination nor inoculation experiments had succeeded in demonstrating its presence. He gave three hypotheses to explain them: (1) that they are due to unknown microbes which rejoice in a soil impregnated by the products of the tubercle bacillus; (2) that they are due to the tubercle-toxin itself, and (3) that they are due to multiple implantations of attenuated tubercle bacilli. He inclined to prefer the last of these. We shall frequently recur to this most interesting topic when we come to catalogue that department of the clinical museum (Polyclinic) which deals with tuberculous affections of the skin, such as Lupus in all its various forms, Bazin's malady, Lichen scrofulosorum, and the like. In the meantime we heartily thank M. Darier for the expression "attenuated tubercle-bacilli." It will be found very convenient.

*The Nature of Eczema.*¹

Nothing that could be deemed both new and valuable was elicited in the discussion as to the parasitic origin of eczema, although men of no less fame than Unna, Galloway, and Brocq took part in it. We may, however, note with pleasure in this and several other departments of pathology an increasing willingness to accept the suggestion of partnership causation in disease. A few years ago enthusiasm for the discovery of some one specific cause for every specialised form of disease dominated the investigations of all our younger school of observers to an extent which prejudiced the success of their industry, and led them into unfruitful fields of research.

¹ *Lancet*, August 18, p. 534.

MUSEUM NOTES.

ILLUSTRATIONS OF FRAMBÆSIA OR YAWS (*Frambæcial Syphilis*).

OUR collection of drawings, photographs, &c., in illustration of the disease known as Yaws—but which ought possibly more correctly to be named frambæcial syphilis—is one which for its extent and value is probably without a rival. The subject is one which well permits of pictorial illustration, and which also emphatically requires it. It is only by the aid of portraits, and more especially of photographs, that we can keep close to the facts and escape being confused and puzzled by verbal descriptions which must always be more or less vague.

The chief contributions to our collection have been the following:—

(1) A number of photographs given by Dr. Numa Rat, illustrating yaws as observed in the West Indian Islands.

(2) The plates published by Dr. Alford Nicholls, in his valuable Government Report on yaws. These are, many of them, coloured portraits of yaws-patients, or careful studies of special lesions, and with them are a number of representations of sections of skin showing the histology of the yaws growth and also illustrating a form of microbe often met with and supposed to be peculiar to it.

(3) The plates published by Prof. Breda of Padua illustrating the conditions present in some yaws-patients who had returned to Italy in what may be called the tertiary stage. Some of these have been copied in a volume issued by the New Sydenham Society. They show affections of the tongue, larynx, penis, and other parts, and are such as, were the disease admitted to be syphilis, would be called gummata.

(4) An Atlas of beautiful water-colour drawings by Sir William Kynsey. In this atlas, which contains upwards of thirty or forty figures, all forms of yaws are represented. The drawings were made in Ceylon, and illustrate the disease which is there known as Parangi. They prove beyond a doubt that the parangi of Ceylon and India is identical with the yaws of the West Indies and Africa, and the Koko of the Fijis.

(5) Photographs given by Dr. Arthur Powell and illustrating the appearances of Parangi in natives of India. They show also the eruption at different stages.



A Yaws fungus on the ankle of a negro. (*From a Photograph by Dr. Rat.*)

(6) A stereo-photograph given by Professor Petrini of Galatz, showing framboesial syphilis in a European woman.



Petrini's portrait of Framboesial Syphilis. (*From a Photograph.*)

(7) Photographs given by Dr. Daniels, formerly of the Fiji Islands and now of British Guiana. One of these is of special value as demonstrating that the eruption known as Koko and indigenous to the Fijians, is without doubt identical with Parangi of Ceylon, and Yaws of the West Indies. Others establish the type of the disease as seen in British Guiana and one series of four shows it on the skin of an English boy.

(8) A photographic portrait showing frambœsial syphilis in an Englishman. This photo has been lithographed and published in



Frambœsial Syphilis. The Yaws of England. (*From a Photograph.*)

my "Achives of Surgery." It has been pronounced by good authorities to be an excellent representation of the appearances usual in yaws, but it was unquestionably syphilis and it had followed an indurated chancre on the penis.

Most of these illustrations are mounted in books, but some of the more important are displayed in frames. It would be tedious to attempt to describe all, and instead of doing so we shall presently attempt to classify them according to the nature of the fact which they appear to illustrate and the teaching which they convey. It will be convenient however, in the first place, to say a few words respecting those which have been placed in frames.

The large coloured portraits five in number, all representing Negroes, which are to be seen over the door in the lower museum, have been copied by Burgess from photographs. The originals were negroes in the West Indian Islands under the observation of Dr. Alford Nicholls. Two of them show the exanthem eruption of yaws (secondary eruption) on the back and front of a lad. The close resemblance of the eruption, in its arrangement and general aspect, to that of syphilis must strike every one. In three other illustrations what is known as "the crusted granuloma of yaws" is shown. Large fungating granulation-masses are seen on the forehead, face and limbs, most of them covered with crusts. These probably represent a somewhat exceptionally severe form of yaws, but several others of our photographs approach them closely. It is to be understood that these fungating growths, under appropriate local and constitutional treatment, will wither away and but rarely leave any definite scar.

In another frame are placed six figures, all being photographs presented by Dr. Daniels, of Georgetown, British Guiana. Four of the portraits are those of an English boy, and the fifth is that of a negro. They are of value as showing that the granulation masses are much smaller and less conspicuous in the white patient than in the dark. It is stated that in the English boy the eruption was receding, but it may be questioned whether it ever persists long, or attains any exaggerated development in Europeans. As regards climate both these patients were under the same conditions, and it is not unfair to suggest that difference in race may explain the minor severity in the European. At any rate we may remark that no portrait or patient illustrating yaws in a severe and persistent form in a person of European descent has ever been brought under our notice.

There is no feature in these portraits of the English lad which

would strike the observer as in the least unusual if he were told that the case was one of syphilis.

In a smaller frame are placed three photographs from Georgetown patients all given by Dr. Daniels. Two of them are from the same patient, and represent the eruption when of three months' duration. One of these shows the granulation patches (condylomata) on the prepuce and skin of penis. The third portrait from a coolie shows the eruption in a later stage, fifteen months or more, and more nearly approaching the appearances of a tubercular form of lupus.

The illustrations given by Dr. Alford Nicholls, in his Government Report on yaws, are of great importance as enabling us to appreciate what is meant by the terms used, and in some instances to form an independent opinion as to the real nature of the disease delineated. We shall quote Dr. Nicholls' designations in his own words. He heads these portraits "*Illustrations showing the local manifestations of YAWS and some of its complications.*"

"Fig. I., *Showing Lupus and Yaws.*" This figure shows most extensive scarring of the face, cheeks, eyelids, &c., with destruction of the lips and nose. It is far more like the ravages of syphilitic serpiginous ulceration than those of tubercular lupus. We may probably understand from the designation given that Dr. Nicholls regarded it as a sequel of yaws, and that he did not suspect syphilis.

Figs. II., III., IV., V., VI., VII., and VIII., show various forms and sizes of the "encrusted granuloma," the supposed typical lesion of yaws. None call for special notice excepting perhaps VII. in which "an annular granuloma" is said to "enclose healthy skin." It is probably an example of coalescence.

Fig. IX. shows the whole back of a negro, and has for those who assert that the eruption of yaws is always monomorphous and always framboesial, the rather startling description "*showing the maculæ or squamous patches—Dartres.*"

Fig. X. is of much interest on account of its close resemblance to syphilitic sores on the soles of the feet. The patches are almost symmetrical and are abruptly margined. It is described as "*showing granulomata about the heels, 'tubboes' and dermatitis, 'crabs' at other portions of the sole.*"

Fig. XI. bears a yet more close resemblance to forms of

syphilitic eruption not infrequently seen on the soles of the feet. There are large denuded areas but no definite granulomata. The feet of two different patients are represented.

Fig. XIII. is described as "*showing the encrusted granulomata on the mucous membrane of the mouth.*" It shows well a condylo-matous excrescence at the right commissure of the lips involving the adjacent prolabium, but it can scarcely be allowed to show anything affecting the mucous membrane of the mouth, for the negro's mouth is shut. The expression may, however, suggest a doubt as to whether Dr. Nicholls is inclined to assert the absolute freedom of the mucous surfaces which some observers claim as a peculiar characteristic of yaws.

Fig. XIV. shows hideous destruction by phagedænic ulceration of the lips, nose and cheeks, and is very suitably described as "*showing destructive ulceration of the face, nose, and mouth, due to tertiary syphilis that appeared during an attack of yaws.*" This portrait is proof that during outbreaks characteristically yaws, conditions characteristically syphilitic may show themselves. Its lesson in this direction is strongly enforced by the next portrait, Fig. XV., which is described as "*showing lupus of the nose and face which came on during an attack of yaws.*" Here there is no suggestion of syphilis, yet the ulcerative destruction of the nose is not in the least like that of tubercular lupus, and is exactly like that of phagedænic syphilis.

We may claim then that Dr. Nicholls' plates prove conclusively that in the disease which he diagnoses as "yaws," eruptions on the soles of the feet, like those of syphilis, are common; and that in rarer instances the nose may be destroyed by ulceration just as in syphilis. We have already adverted to the fact that he clearly recognises polymorphism and squamous as well as granulomatous eruptions.

The remainder of his plates, XVI. to XXX., have no great interest for us, though they are the result evidently of much industry. They illustrate the microscopic anatomy of "the granuloma, the macula, the squama, and the papula." The very names used here suffice to again prove that Dr. Nicholls does not regard the eruption of yaws as monomorphous.

It may be convenient to further classify our descriptions of the portraits in our collection under the following heads.

Portraits showing the Primary Sore.

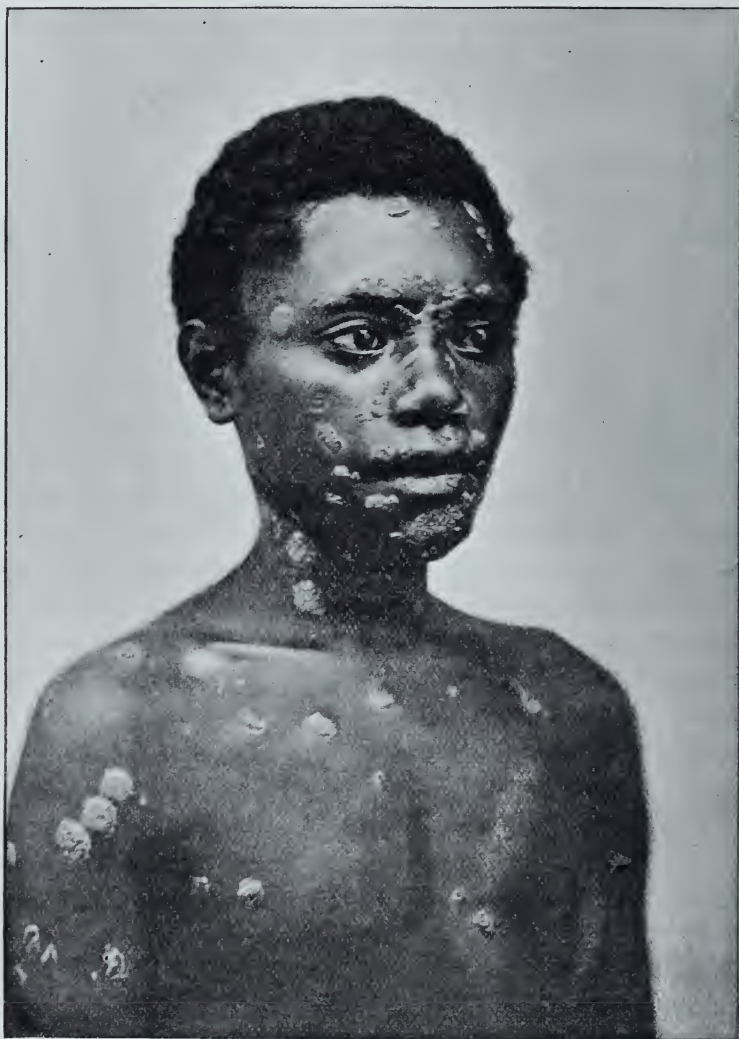
Of delineations of the primary sore, what has been called the "mother yaw," we have no single example. It is a remarkable fact, and one of which the most has been made by those who contend that yaws is not syphilis, that it has no primary sore. Yet no one has had the hardihood to suggest that it spreads by aerial infection. All admit that contact is necessary and, as media of contagion, flies, &c., have been suggested. It has been supposed that previously existing sores or abrasions often receive the contagion.

The suggestion of those who hold that yaws is syphilis is that it is acquired usually by a non-sexual infection, the primary sore being on some other part than the genitals and very usually overlooked. They urge that chancres on the limbs seldom do present typical characters and that they are often, indeed usually, not identified. Thus it is hinted that the frequent failure to discover the primary sore in yaws need not surprise us much. That the older writers did recognise the parent yaw is unquestionable, and the experiments of Charlouis have made it certain that a primary sore with a definite period of incubation, with bubo and tendency to general adenopathy, does precede the outbreak of the yaws eruption. The intervals between the several stages were, according to his results, exactly those of syphilis. Yet we must admit that we have here no photograph or other representation of such primary sores. No doubt it is merely a question of zeal on the part of observers, the simple fact being that the eruption is usually the first thing which attracts attention. In the Fijis and some other places mothers are said to inoculate their children, and in such instances, of course, there must necessarily be a primary sore. We shall no doubt be able before long to add to our collection some representations of these sores.

Portraits which prove that Yaws is the same Malady in Different Countries.

The evidence given by our collection on this point is most valuable, the more so because some writers, unable to reconcile their own theories with the statements made by others, have inclined to doubt the diagnosis of others and to suggest that syphilis rather than yaws may have been the subject of their

observations. No one, however, going over this collection of portraits, can doubt for a moment that the eruptions seen by Sir W. Kynsey in Ceylon, by Dr. Arthur Powell in India, by Dr. Daniels in



Koko. The Yaws of the Fijis. (*From a Photograph by Dr. Daniels.*)

Fiji and British Guiana, are one and the same malady with that which is the subject of Dr. Nicholls' report. The framboesial character of the eruption is most definite, and to deny that they are all

“yaws” is simply to throw overboard altogether the granulomatous eruption as a characteristic of yaws and to leave the latter wholly featureless. We are especially interested to assert that Dr. Daniels’ portrait of Koko, from the Fijis, is just like the rest, because in some respects yaws may be asserted to exist in the Fijis under somewhat peculiar conditions and to the total exclusion of ordinary forms of syphilis. More is asserted as to the monomorphism of yaws in the Fijis than is said of it in any other region.

Portraits illustrating the Secondary Eruption.

These constitute the greater number of our portraits. In all cases they show an eruption which is arranged with bilateral symmetry and is scattered over the trunk, limbs and face. It is often very severe and abundant on the face. It is usually more or less fram-bœsial, *i.e.*, granulomatous, in character. The raspberry or mulberry-like mass of granulation-tissue is usually capped by a dirty yellow crust, but this crust is never imbricated or limpet-shell-like as are the crusts of rupia. The crust covers a little fungus and not an ulcer. In many of our drawings the size of the granulomata varies much, being sometimes very small. In some, as for instance in Plate IX., of Nicholls’ and in some of Kynsey’s there is reason to believe that the eruption was not granulomatous at all but papular or squamous. The abundance and general distribution of the eruption appears to be usually in relation with the stage of the disease. When, as was the case in several instances, the eruption had remained out for a year or more, it usually receives some modifications and is less general in distribution. In some portraits the production of a well branched, firm papilloma (like cauliflower buds) is to be noted. These growths are usually seen sparingly located in certain special regions such as the hands or feet. (See woodcut, p. 178).

Portraits illustrating the occurrence of Bone Disease in Yaws.

A portrait for which we are indebted to Dr. Arthur Powell, of Kalain (Assam), illustrates a most interesting condition of periosteal dactylitis as the result of yaws. It is copied in the appended figure. The hands of a mother and her infant are represented, and in both it will be seen that several of the proximal phalanges are much enlarged. It is not joint disease, but fusiform enlargement of the

phalanx. Dr. Powell has published the case and informs us that under mercurial treatment the bone affection completely disappeared



Dactylitis in a mother and her child after Yaws. (*Photograph by Dr. Powell.*)



The Infant from the same case. (*Dr. Powell.*)

in both patients. In this instance the mother, a woman of 37, was inoculated in the scar of a breast-abscess and developed the eruption of yaws in January, 1895. She was confined in April, 1896, and her child, which at first appeared to be healthy, developed yaws seven months after birth. The periostitis occurred in the mother two years and six months after her yaws, and in the child in the eighteenth month after birth. We appear to have here a good instance of inheritance of yaws, an occurrence which has been denied by some writers. The early occurrence of the periostitis in the infant makes it far more likely that it was inherited than acquired after birth.

The importance of this case as an example of periosteal dactylitis from yaws is considerably increased by the fact that Sir William



Dactylitis; lupoid ulceration, &c., after Yaws.

(From Sir W. Kynsey's Drawings.)

Kynsey has given us in the portraits, Nos. XI.-XIV. of his atlas, an excellent illustration of precisely the same condition. In this case the patient was a Moorish boy named Adam, who lived by begging. He had enlargements of several bones, tibia, &c., and many large lupoid cicatrices. He was 16 years of age, and had suffered from the yaws-eruption in infancy. He said that there were many in his village suffering in a similar manner. It might be suggested by those who hold that yaws is not syphilis that this lad was the subject of syphilis and not yaws, but we have the diagnosis of a highly skilled observer, and it is corroborated by the fact that in Dr. Powell's cases the dactylitis was exactly the same, whilst the previous occurrence of yaws was undoubted.

Portraits which go to prove that Gummata and other Tertiary Phenomena do follow Yaws.

Some recent writers have sought to discredit the statement, respecting which all the older ones were unanimous, that bone disease, lupoid ulceration of the skin, and other tertiary symptoms, are met with after yaws. The collection of portraits before us show this class of affections in abundance and in much variety. We have already cited the cases of periosteal dactylitis, of which independent observations are recorded by Dr. Powell and Sir William Kynsey. We have also quoted Dr. Nicholls' descriptions of his own portraits as "Lupus and Yaws," "Lupus of the nose and face which came on during an attack of Yaws," &c.¹ We have also referred to the numerous illustrations of dermatitis of the soles of the feet (and presumably of the palms also), which produces conditions not to be distinguished from those known as syphilitic palmar and plantar psoriasis. Of these Dr. Nicholls gives repeated portraits, but by far the best is one contained in Sir William Kynsey's atlas (Plate III.), which in accuracy of delineation leaves nothing to be desired. (It may be of interest to note here that this plate very accurately represents the condition of the sole which existed in the patient who was made the subject of demonstration at the recent meeting in the Tropical Section of the British Medical Association at Ipswich.)

¹ In order to facilitate easy reference these portraits from Dr. Nicholls' Report have, since the above was written, been placed in an open frame.

In addition to what we have named, Sir William Kynsey's atlas contains the following. Plate XIII.; "Extensive lupoid ulceration of the hand, which, on healing, caused contraction of the fingers and thumb." Plates XIV., XXV., with dactylitis, show large lupoid scars in various parts. Plate XVII. gives us "a typical parangi (yaws) cicatrix." It represents an abruptly margined scar with lupoid and advancing borders on the shoulder. The scar is as large as an outspread hand. Plate XVIII. shows ulceration involving one nostril with elevated edges and not wholly unlike rhino-scleroma. It is described as "lupoid ulceration of nose and upper lip said to have followed eruption."

The plates taken from Breda's monograph illustrate in many instances conditions closely allied to infiltrating gummata but associated also with papillomatous growths. These were observed in the Institute for Dermatology of the University of Padua, their subjects being Italians who had resided in Brazil and had there contracted what had been diagnosed as "framboesia." It may be alleged by those who differentiate between yaws and syphilis that these were cases of syphilis and not of yaws. On this supposition—or rather form of expression—they afford good proof that syphilis may produce frambœsial forms of growth. If accepted as being yaws they conclusively refute the statement that the mucous membranes are not liable to be affected in that disease. As regards the similarity of the lesions to gummata the author describes "a compact mass of tissue in the prepuce as large as a chestnut." He speaks of "hard nodules" repeatedly, and at one place (page 269) "on the hard and soft palates there was not so much an ulceration as development of nodules and nodes," . . . "all of them were firmly attached, compact, and gave rise to no pain." At page 282 he again writes: "The disease gives rise to infiltrations and painless ulcers, in which, as in lupus, plasma cells are present and a tendency to considerable fibrous-tissue-increase, and lastly giant cells and caseous degeneration are wanting."¹ Although Prof. Breda argues that his cases were neither tuberculosis nor syphilis but the result of a specific micro-organism which he had discovered, not many of his readers who have seen his plates, &c., will doubt that

¹ See Prof. Breda's monograph in New Syd. Society's volume clxi., page 261.

he had to do with intractable forms of syphilis, and that the Brazilian physicians who regard "Boubas" or "Frambœsia" as a form of syphilis are right. No one can read the description of the early stages of the disease given by the author at pages 268 and 269 and not feel convinced that the Brazilian "boubas" is the same malady with that known as frambœsia or yaws in other parts, nor without at the same time entertaining a very strong suspicion that he is dealing with syphilis as conveyed in accidental contagion in a peasant community.

Portraits of Yaws in two Englishmen, proving that Polymorphous Eruptions, not to be distinguished from those of Syphilis, follow Yaws.

These portraits concern the two recent cases which I have published in Archives. The history in the two is absolutely parallel. In each the patient, an Englishman living on the African coast, who had never had syphilis, became the subject of yaws. In one instance the patient was a surgeon, and the primary sore, which fungated, had been caused by a prick from a hypodermic syringe which had just been used in a yaws case. In the other patient the primary sore was on one wrist, but the source of contagion was not known. In both an eruption followed of frambœsial type, which was diagnosed as yaws by experienced observers on the spot. Both patients came over to England, and when seen by me had polymorphous, lichenoid and squamous eruptions. Both were cured for the time by specific treatment. One of the portraits exhibited was from the ankle of the surgeon, and shows a yaws fungus as characteristic, but not so large, as that shown on page 178. The portraits from the other show only the condition of his scaly and papular eruption, for the frambœsial stage had almost wholly passed. The subject of these last portraits was produced at the meeting of the British Medical Association at Ipswich before the Tropical Diseases Section, and by a unanimous vote the meeting declared its acceptance of the diagnosis of syphilis.

Concluding Remarks.

In concluding these descriptive notices I may venture to express the confident opinion that no one can go patiently through our

collection without arriving at the conclusion that the disease known in various countries as yaws is fundamentally and essentially syphilis. It may be that some microbic addition is made to the specific virus which gives proclivity to the granulation growths which have been supposed to be characteristic. This is a possibility, but that for one thing the syphilitic virus is present admits of but little doubt. There are also certain strong reasons for thinking the complication suggested improbable and for believing that the peculiarities assumed are wholly due to climate and race.

Those who have lived in districts where what is called "yaws" is common are sometimes prone to hint that those who have not done so are not in a position to correctly appreciate the facts. Thanks to the artist's pencil, and above all to photography, difficulty on that score is to a large extent overcome. Our collection of portraits is international, and I venture to believe that anyone who will patiently go through it will be in many respects better able to judge of the nature of the disease than an observer who, although an eye-witness, has been restricted to a single locality.

CORRESPONDENCE AND ANSWERS.

A NEW MODE OF USE OF SULPHUR FOR SCABIES.—Dr. Sherwell, of Brooklyn, thinks it a great improvement in the ordinary treatment of scabies to rub the surface, after a bath, lightly with sulphur lotion and then make the patient sleep in sheets which have been powdered with sulphur. The plan, we may confess, does not sound more attractive than the ordinary sulphur bath and Peruvian balsam.

* * *

S. T. C.—Although, as you suggest, some of the exanthemata are better got over in childhood, young children should be very carefully protected from the contagion of scarlet fever. The liability to contract it diminishes with the increase of age and so also does the ratio of mortality. The decrease is very definite after the age of 2. The liability to mumps also diminishes with age and is almost extinct in old age. If, however, cases do occur to adults they are sometimes very severe, and a malady which is seldom really serious in childhood may, in an adult, prove fatal.

* * *

X. Y.—"THE Governance of Helth," "Regimen Sanitatis," was a poem in Latin hexameters composed for Robert, the eldest son of William the Conqueror, at the end of the eleventh century, by the School of Medicine at Salerno. It is said that above 160 editions were published.

TRANSITORY SUBCUTANEOUS INDURATIONS OVER BONES.—The following description of a very unusual symptom has been supplied to us by one of our members, Dr. G. Crichton. The patient is a soldier, but there is no reason to suspect syphilis. Dr. Crichton writes, under date May 17 :—

"To-day I have seen the trooper of whom I spoke. Over the inner half of each superciliary ridge is a prominence which extends across from one ridge to the other. On the back of the left wrist, where there has been a swelling for some weeks, on this occasion there was nothing. I felt the spot and in three or four minutes a swelling rose a little. After about ten minutes it was plain enough. I then painted it with some sort of drying stuff containing belladonna. When I came away the swelling had shifted itself to the proximal edge of the paint.

On the inner edge of the right foot are three nodules which have been there for weeks. The middle one only is tender. The lowest is over the first metatarsal (upper end). The knobs come for variable times. His sister (who mostly is nursing him) rubs them and they disappear.

"To-day these were all. They generally appear over a bone, over shaft or near the end. One this morning over the bend of right elbow. It was disappearing when I was there so I cannot quite locate it (I think over head of ulna).

"If you took a boy's marble and bisected it, not through the equator, but (so to say) through the tropic, and placed the less half under the skin, you would have the exact appearance presented by these knobs. Otherwise, the man is sinking from tuberculous disease of both upper lobes—no abnormal temperature in the *day* time now."

The patient was too ill to be brought to the Polyclinic, being confined to his bed. The suggestion occurs that the swellings described by Dr. Crichton were of the nature of subcutaneous urticaria.

* * *

COMMISSARIAT SHORTCOMINGS IN SOUTH AFRICA.—A correspondent sends us the following conversation of doctor with patient, for the truth of which he vouches :—

Patient : "You see I am just home from South Africa, and I may have suffered from the food."

Dr. : "Then you really have encountered hardships ?"

P. : "Oh yes ; we had but little to eat. Our meat was at one time all horse-flesh."

Dr. : "Well, horseflesh is wholesome."

P. : "Yes, but we had not enough of it, and besides, it was from horses that had been ill and perhaps had died."

Dr. : "You don't say so."

P. : "Indeed I do ; it was horrible stuff. The Kafirs wouldn't touch it."

Dr. : "Did your health suffer ?"

P. : "Well, I got thin, but I was not ill. Many of our fellows were, though ; some had scurvy, and some, I believe, died of it. One man, I know, went insane from sheer starvation."

Dr. : "Died of scurvy ! Could you not get green vegetables ?"

P. : "Oh no, nothing of that kind."

Dr. : "I did not catch what part of the army you told me you were with."

P. : "With General White in Ladysmith."

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

VOL. III., No. 10.—OCTOBER, 1900.

LEPROSY IN RELATION TO SOUTH AFRICAN COLONISATION.

THE existence and steady increase of leprosy in South Africa has long been a subject of much anxiety to the Government of Cape Colony. Recently Natal, where it is a wholly new disease, has taken the alarm, and now that the war is over and the two Republics annexed to the Crown, our Home Government will be compelled to give its advice. It is indeed much to be desired that a line of action should be adopted in which all the colonies and protectorates in any sense under British rule should be associated. Already in Cape Colony itself stringent laws for the compulsory segregation of lepers exist, and are to some extent enforced. The two Dutch Republics had their own regulations, and in Natal alarmists in the House of Representatives are now clamouring for enactments which, as they think, will ward off an impending calamity.

This is a matter in which those in authority naturally look for guidance to our profession, and it is one in which the claim for conscientious investigation on our part and a deliberate verdict is very strong. It will not do to return flippant and ill-considered answers to the questions—does leprosy spread by contagion? and ought seclusion of all lepers to be enforced? They are not matters

in which ill-informed opinion is of any value, or into which speculative pathology ought to be allowed to intrude. They concern the welfare and happiness of thousands, and should be replied to only after the most careful investigation of the facts. We venture to commend that investigation as being in some sense a duty to many members of our profession who have hitherto not so regarded it. It is one of the pressing questions of the time and it has a paramount claim upon our hearts as well as upon our heads. If a creed which had its origin in mediæval ignorance is now, without reference to the general facts, to be allowed to receive what to many may seem to be conclusive support, from the supposed facts of bacteriology, a line of conduct may result which in the future may cause bitter regret. Those facts may possibly assume developments of which as yet we have little conception, and the crude reasoning which has been based upon them may be found to have wandered very far from the truth.

There is no room for doubt that the belief in the contagiousness of leprosy, which on the general evidence regarding the malady was fast dying away, has received new life from Hansen's discovery of a bacillus. "A parasite is its cause, therefore it can only spread by contagion," is the line of reasoning which has been hastily adopted by a large section of the profession. It has also been pressed upon the public as an argument the cogency of which it is impossible to deny. It may be sufficient for us in urging the need of caution in this assumption to mention only one source of fallacy amongst several. It is this—that the bacillus may, after all, just as likely gain access to the recipient in some article of food as by personal contact. It is admitted on all hands, even by the most ardent advocates of modern doctrines of contagion, that the tubercle bacillus often reaches its host in raw meat or unboiled milk, and what is true of it may easily be true also of the leprosy bacillus.

It is not in the least necessary for those who think segregation useless for the prevention of leprosy, and who hold that laws for its enforcement are a most cruel tyranny, to attempt to prove that the malady cannot possibly be contagious. It is sufficient to show that such is not the ordinary mode by which it spreads, and in proportion as it can be proved to be the exception, in that ratio will faith in the efficacy of such measures diminish.

We have devoted considerable attention in the pages of the *POLYCLINIC* to the examination of the facts as to leprosy in South Africa. We have desired to place our readers in a position of ability to judge for themselves, and have, we trust, shown no desire to unfairly influence their decision. We have given at pages 311, 388 and 46, a somewhat detailed analysis of the evidence produced before the Leprosy Commission at Cape Town six years ago. At the same time two of the standing committees of our College—that in reference to Climate, and that on Leprosy—have been engaged in sifting evidence bearing upon the same question. An instalment of the report of what has been done in the latter is given at page 243 of our present number and more will soon follow.

The main facts on the subject may be easily and briefly stated. That its prevalence has been coincident with European colonisation there can be no doubt. It may possibly have existed as an indigenous malady at a few places on the coast, and it may possibly have been known amongst the Hottentots, but if it were so it must have been exceedingly rare. The first mention of it with which history can deal is in three Dutch colonists on a farm near Cape Town. There was a Government inquiry into these cases, and not a hint occurs that these Dutchmen thought they had contracted it from their slaves, or that it was indeed known amongst the Hottentots. The three were on one farm, they were advised to remain at home, and no further mention of the disease either amongst natives or colonists occurs for half a century. Probably, however, it had been slowly increasing in the small district which then constituted Cape Colony, for in 1817 it became necessary to found leper villages. The chief of these was near to Cape Town itself, and from it a transference to the now notorious Robben Island took place in 1846. The Hottentots and bastards were the chief victims, but no class and no race was wholly spared. That the Kaffir race had originally been free is admitted on all hands, but during the last half-century many Kaffirs have suffered; so, too, have Malays who had been early brought by the Dutch to conduct fisheries at Cape Town and other places on the coast. For long, leprosy would appear to have been prevalent chiefly near the southern coast. Of late years, however, it has spread gradually to the north, and has reached even the northern limits of the Transvaal. Although, however, so widely prevalent, it is still a

rare disease, its victims being scattered, one or two here and there. It is not possible to mention any single locality which has obtained an evil repute as being a leprosy centre. Those who suffer never know how they have obtained it. In a large majority of cases they aver that they had never seen a leper, and the ordinary creed is that it comes from "catching cold." The instances in which lepers have continued to live with their families and to engage in the ordinary pursuits of life without any apparent ill results are abundant, and the creed of the public is that it is in no way contagious. That creed is shared by many medical men who have had opportunities of observing the facts, but is controverted by others, who allege that the presence of a bacillus makes it certain that it must spread by contagion. Up to present times there are large districts included in British South Africa in which leprosy is quite unknown. These are chiefly those inhabited by Zulus and those in which the population is very thin and chiefly native. It was until quite recently absolutely unknown in Caffraria, and it was only in 1843 that the first cases occurred in Natal. It is alleged on high authority (Sir Theophilus Shepstone and others) that when it showed itself in some Kaffir tribes in Natal no possibility of communication with infected races had occurred, and that there was nothing in the habits of those attacked which could in any way explain it. The Kaffirs themselves attributed it to witchcraft. It developed, not as an epidemic, but only very sparingly, and, as in other places, affecting one here and one there at places somewhat distant from each other. The whole number of cases in Natal may still be counted by a few hundreds, although sixty years have elapsed since it was first observed.

Such is a brief sketch of the facts with which we have to deal. In some strange way it would seem that European civilisation has been the means of taking leprosy into South Africa and of causing its spread,—sparingly, it is true, but yet quite definitely,—into almost all parts into which colonisation has advanced. Meanwhile, it is to be noted that the colonists themselves came from countries which were free from the disease, and have remained comparatively free.

MARY LAMB'S ILLNESS.

It is well known that Mary Lamb, the ten years elder sister of Charles Lamb, was liable to recurring attacks of insanity. In various fragmentary references the facts of her illness have been given with detail sufficient to make her case of much psychological interest. She afforded an example of recurring functional disturbance of the emotions and reason which left no permanent ill results. During the intervals of health, which were long, Mary Lamb possessed a clear and powerful intellect, and was the object of warm attachment on the part of her brother and many friends. At the age of 30 (1796), in her first attack of excitement she stabbed her mother to the heart. After a period of confinement, she was liberated under her brother's care, and during the following ten years she wrote, in conjunction with him the celebrated "Tales from Shakespeare," "Mrs. Leicester's School" and "Poetry for Children." She lived to be an old woman, but was during the greater part of her life liable to returning attacks. Her friends and herself became well aware of the premonitory symptoms, and, remembering what had occurred on the first occasion, she always willingly consented to be placed in confinement. What the disturbing influence was to which the attacks were due was never ascertained. That it may have been in some way connected with the sex-functions is suggested by the following description of the advent of an attack given in one of Coleridge's letters. It should be said that there was insanity in the family, and that Lamb himself at the age of 21 was under confinement for a short time.

Under date April 4, 1803, that is, seven years after her first attack, Coleridge wrote to his wife: "I had purposed not to speak of Mary Lamb, but I had better write it than tell it. The Thursday before last she met at Rickman's a Mr. Babb, an old friend and admirer of her mother. The next day she *smiled* in an ominous way; on Sunday she told her brother that she was getting bad, with great agony. On Tuesday morning she laid hold of me with violent agitation and talked wildly about Charles Dyer. I told Charles there was not a moment to lose; and I did not lose a moment, but

went for a hackney coach and took her to the private madhouse at Hugsden. She was quite calm, and said it was the best to do so. But she wept bitterly two or three times, yet all in a calm way."

In December, 1794, Coleridge had written of Lamb: "His sister has lately been very unwell confined to her bed, dangerously. She is all his comfort, he hers. They dote on each other. Her mind is elegantly stored, her heart feeling." (Letter to Southey.)

The form of intermittent or recurring insanity to which Miss Lamb was subject is doubtless one well-known to alienists. Her case is remarkable, not so much on account of its rarity as for its strongly marked features. The career of the poet Cowper was a more or less close parallel, and others might be cited. A poem now quite forgotten, entitled "Madness, or the Maniac's Hall," was written by a gentleman who had himself had much experience of the scenes and characters which he described. He was a well-educated man, and although his literary work by no means displays genius equal to that of "Mrs. Leicester's School" it had yet very definite merit. This gentleman was like Miss Lamb, liable to fits of excitement followed by depression, and like her he used to recognise the indications of their advent and voluntarily place himself under care in an asylum. Eight or ten months usually sufficed, and then he would return to his friends and enjoy several years of sanity, acting in all respects as a sagacious and well-conducted man. It was during one of these intervals that he wrote the poem referred to.

The completeness of the recovery in cases such as these may serve to impress the lesson that some forms of insanity are to be regarded almost purely as disturbances of function, and by no means implying anything of the nature of structural change. That they may tend in the long run to produce such change is very probable or possibly inevitable. As in the case of epileptics the explosions of nerve force no doubt, as a general result, tend to weaken the centres. We regard it as probable that their subjects tend to lapse prematurely into the imbecillity of age. During the middle periods of life, however, there may be no evidence whatever of deterioration, and the periods of excitement may even seem to have the effect of giving activity to a character otherwise somewhat torpid.

If we make enquiry as to the nature of the exciting causes which evoke attacks of recurring insanity, and seek to explain the

periodicity of their incidence we engage in an investigation full of obscurity. We may, however, instructively keep in mind the general laws as to periodicity under which a planetary life is maintained. We have day and night and the seasons, and we know well that the changes in surrounding conditions which these bring with them are not without their influence upon our mental states. Some persons, perhaps many, are liable to autumnal melancholy, whilst others find rather a source of discouragement in the new demands on energy which the season of spring seems to suggest. It does not, however, seem probable that any simply meteorological considerations will explain such cases as we have cited. They are more definitely connected with the individual than with his surroundings, and to find their elucidation we must go deeply into the more humiliating aspects of man's animal nature and zoological descent. He has inherited proclivities from which not even the highest development of his moral and intellectual endowments enable him wholly to escape. Prominent amongst these, but by no means the only one, is that of the sexual system. It is well-known that the lower animals when under conditions of enforced restraint as regards sexual intercourse are liable to periods of disturbance not dissimilar to insanity. It is known, also, that certain laws of periodicity are also in force in reference to these functions. Menstruation is only one of these, although the most definite. We must not on the present occasion do more than just make the suggestion and remind the reader that most of the conspicuous examples of recurring insanity occur to celibates.

It is quite possible that other large viscera or systems may be like the sex-organs more or less liable to periodic variations in their functional activity. It is possible that the liver may be one of these, and there may be those whose recurring departures from mental health and cheerfulness should be referred to it.

Our concluding observation must be that something may probably be learned by noting the peculiarities of certain disorders, not of a mental character which display periodicity, or at any rate tendency to recur. All gouty affections do this, and although weather and season may in part explain it, we may be permitted to doubt whether they do so wholly. Those liable to arthritic iritis may have an attack in the same week of each recurring spring for

years together. Erythema multiforme often shows a similarly exact periodicity. The most remarkable example of liability to recurrence after long intervals and complete immunity between them is, however, afforded by what is known as lichen planus. In this malady a dermatitis of great severity and of many months' duration may pass away completely and leave the skin in a state of perfect soundness, which may last for years before another and probably more severe attack occurs.

MANCHURIA.

MANCHURIA lies between Siberia in Asia and China, and is to China what Canada is to the United States.¹ It is outside, that is north of, the great Chinese wall, and a good Chinaman dying in Manchuria is anxious to be carried through the wall for burial.² The Manchus are a Tartar race and in common with the Chinese of the Mongolian family, but differing very considerably from Chinese. They are an energetic and able people. The Reverend Alex. Williamson, who travelled through Manchuria in 1869, wrote of it: "I have found it a country of much interest and great promise, and not that barren, bleak, and lawless country generally supposed." The Archimandrite of the Russo-Greek Mission at Peking, who went through it a few years later, wrote: "Nature welcomes the traveller as a rare guest and surrounds him with her choicest gifts." He described prairies teeming with vegetation, but had to admit also the frequency of dismal swamps and thick forests. The insect plague is gadflies "which attack man and beast with relentless fury." The trees, plants, birds, and many of the animals are those which would be met with in Scotland, but to the fauna must be added the wolf, wild boar and tawny striped tiger.

¹ It does not, however, extend east to west over the north of China as Canada does over the States, but rather has the form of a parallelogram, the axis of which runs north-east whilst the southern end rests on the northern boundary of China.

² We must, for the reader's convenience, point out a curious clerical error in Younghusband's map as to the position of the Great Wall. It appears to us that the position so designated is not that of the *Great Wall*, but of the "*Osier Wall*," a very different thing.

The highway from Peking runs north-east, through the great wall, along the shore of the Gulf of Lian-tung to Muckden (Shinyang), the capital city. Mukden is the Edinburgh of Manchuria. It has numerous inhabitants, plenty of shops, and amongst others, as an index of civilisation, several large bookshops. The whole country is rapidly receiving a Chinese population, which, coming in from the south, gradually supplants the native Manchu. Even the Manchu language is dying out, yet it is this race which has given its present rulers to China.

Comparing Manchuria with Canada, Mr. Williamson writes: "They possess many points of resemblance. A climate similar in many of its features, an equally fertile soil, yielding similar crops, and each having a northern territory famous for its furs, each drained by a great river and possessing a variety of minor seaports. But in some respects Manchuria bears the palm; its climate is a shade less severe, it probably possesses greater mineral wealth, produces cotton and silk, unknown in Canada, and has seaports in the south which are open all the year round.

North of the boundary of Manchuria is Eastern Siberia, of which a recent author (Younghusband) writes: "The Russians are waking up in earnest, and a great future ought to lie before their magnificently fertile tracts. What the Chinese colonists have been able to do on their side of the border is a type of what the Russians could do also, and with a railway to aid in its development, all these regions about the Amur and its tributaries ought to equal the most thriving parts of Canada."

Respecting Manchuria in general, Younghusband writes: "It will be gathered from the narrative that the country is one of extraordinary fertility. Both in this respect and in its climate it seems to resemble the best parts of Canada. It is mostly land formerly covered with forest and consequently the soil has all the richness which the accumulation of decaying vegetation through many ages gives." A very large proportion of the country is even now under forest, though every year the Chinese colonists eat further into it. The population of Manchuria has been estimated at 21,000,000, but of these perhaps not more than a million are native Manchus, the bulk being Chinese immigrants.

One of the most recent accounts of travel in Manchuria occurs

in the early chapters of Captain Younghusband's "The Heart of a Continent." It is from this work that we have already quoted. Younghusband travelled from the coast through Manchuria westwards, and then through the Gobi Desert to the North of India. He was an observant man, and writes with clearness and vigour. His statements more than confirm those of previous visitors to these little-known regions as to the capabilities of the country. Of his original attractions to the expedition he writes: "Our plans now shaped themselves into a journey round Manchuria. It was a country of many interests, and it was but little known. It was the cradle of the present ruling dynasty of China; and the few travellers who had been there described its lovely scenery, its noble rivers, its fertility and natural resources, and the healthiness of its climate."

Younghusband gives the interesting piece of information that "The Chinese and Manchus never milk their cows. They seem to think it disgusting to drink milk. They will eat rats and dogs, but they will not drink milk, or, at any rate, they don't. We missed this simple necessary very much, and eventually had to take large quantities of oil with our food in its place. Millet porridge, vegetable stews, and soups, were their chief food."

"The original Manchurians have," he tells us, "been drafted off with their families to garrison the towns of China proper, and now the Chinese immigrants from the over-populated and famine-stricken districts of China were flowing into these Manchurian valleys, clearing away the forests, and bringing, year by year, more of it under cultivation. They are for the most part strong, hard men, with enormous appetites." At another place, 180 miles west of Mukden, he records that he could not get any good food; "Only some uneatable pork was to be had, and we were obliged, in the meat line, to content ourselves with an egg curry made of salted eggs six months old." Here they were afflicted with a scourge of mosquitoes and midges. "In no part of India have I felt them so much. In the day-time we had midges driving us wild with their irritating pricks, and at night the mosquitoes in clouds. By simply closing the hand a dozen of them could be caught at any time. Of course we had to wear veils the whole day long, and keep our hands in our pockets or wrapped round with cloth whenever we could; but even then we suffered badly, and washing was a positive torture.

Gad-flies were another form of torture invented for these parts. They would attack us pretty constantly, but it was chiefly to the poor animals that they devoted their attention, and the wretched mules were often covered with blood and driven wild by their attacks."

In the swamps by the river (Sungari) they had an experience of mosquitoes which quite eclipsed all former records. "We heard a suppressed kind of roar like that of the distant sea, and we thought it must come from the river. But it was nothing but mosquitoes." They were out snipe shooting, but the mosquitoes gained the day and drove them from the marshes.

Of the Chinese character Younghusband gives us some interesting illustrations. He says that they have little regard for strangers, but much for each other; that they are very cheery among themselves, and can even on occasion show the jovial side in company with strangers. "I should say, too, that their conversation is good; it is certainly bright, and it is very natural and well sustained. Of course, in conversation with Europeans they do not excel; they are lamentably ignorant of geography, for instance, and they generally annoy the stranger by asking whether his country is tributary to China." "A Chinaman is perhaps too celestial, rather too much up in the clouds and above ordinary mortals, and certainly shows too little interest in the common everyday affairs of this world; but he is an interesting man to meet at home, and mingled with the irritation which his superciliousness so often inspires, I often had a feeling of real regard for a man who can aspire to such a lofty standpoint as the Chinaman does, and in his case I felt that it was not all simple self-conceit, for he had in him the pride of belonging to an empire which has stood intact for thousands of years and which was approaching civilisation when we ourselves were steeped in barbarism." He adds: "Nobody can be ruder than a common Chinaman, and nobody can be more polite or refined than a Chinese gentleman when he wishes."

Captain Younghusband relates that he found in many places in Manchuria preparations for defensive war of the most modern kind. At Kirin was a manufactory as well as an arsenal, and magazine rifles, Gatling guns, and field guns, were being turned out in very creditable fashion. In others large cannon had been imported and carried immense distances.

Sansing is the furthest inhabited place of any importance in the direction of the Amur (*i.e.*, towards Eastern Siberia). "The Chinese had erected near by some fortifications of considerable strength." "I was astonished to find a fort which was planned on the most approved European lines and armed with Krupp guns of six or seven tons weight." At Hanchow, again, Captain Young-husband was yet more astonished, on account of the difficulty of access, to find strong forts mounted with heavy Krupp guns. These were, of course, preparations on the part of the Chinese against Russian aggression from the north.

The Chinese immigrants into Manchuria are reported to be "healthier and stronger than their countrymen in the south: the result not only of the climate but also of the abundance, variety, and cheapness of food." (Williamson.)

A Manchu is, as regards his features, scarcely distinguishable from a Chinaman, but his frame is somewhat coarser and stronger.

There are some Mohammedans who keep themselves apart from the Chinese and say that they are from the west.

The use of opium is a comparative novelty. It was unknown a century ago. Now, although contrary to law, the poppy is extensively cultivated. It is said that mandarins receive bribes and wink at the infraction of the law, and some observers give us very melancholy reports as to the demoralising influence of the drug and the increasing extent of its use. (Williamson.¹)

Pigs are much more plentiful than sheep.

At Kirin, the capital of middle Manchuria, a beautifully situated town of nearly 100,000 inhabitants, the food was plentiful but somewhat peculiar. At a private dinner to which the traveller was invited, "Course after course was served up, till we must have had thirty or forty of them, including such delicacies as sea-slugs, shark's fins, and birds' nest soup. The Celestial has a very good idea of the way to look after the inner man. I cannot say, however, that I can bestow much praise upon his liquour department; warmed spirit distilled from rice is not good, and taken as incessantly as a Chinese expects you to take it, it is apt to make you decidedly heavy if not more, and sick as well."

¹ *Journal of the Royal Geographical Society*, vol. xxxiv.

In the Hurka river and its numerous side streams there are abundant fish, mostly salmon. "The natives form dams across the side streams and catch them by hundreds."

After crossing the Singari "we soon entered the open rolling steppes of Mongolia. The cultivation ceased, and with it the villages." The occasional hut of a Mongol was all the trace of human habitation then found, but there were swarms of water fowl around the lakes, and many herds of antelopes. "The chief attraction for us, however, at this period of our journey was the milk and cream we could obtain. What a treat it was, after nearly four months without milk or any of its products, to drink some of the rich delicious stuff which these Mongols brought us."

We have not been able, in the accounts either of Younghusband or of other travellers, to find much detail as to disease in Manchuria. None of them mention leprosy, nor do any definite allusions to malarial fevers or tubercular affections occur. The general impression given is that it is a very healthy district, and the assertion is repeated that its inhabitants are exceptionally well fed. In their avoidance of milk in all forms they possibly escape one of the sources of tubercular infection. Should Manchuria be annexed by Russia we shall probably before long have access to sources of more detailed information. In the meantime the fragmentary information given in the extracts we have quoted are not without their interest.

HEALTH-CONDITIONS IN BULAWAYO.

THE conditions of life in Bulawayo at the present time are peculiar, and not quite such as an uninformed person would expect. The town has risen with extreme rapidity, and now possesses many good buildings and large hotels. It is stated that the rental of one of the best hotels is not less than £4,500 per annum. Yet for the present the place has neither manufactures nor agriculture to depend on. It is as yet the northern terminus of the Cape-to-Cairo railway, and as such naturally attracts travellers, prospectors, officials, &c. There is gold-mining in anticipation, but not yet in certainty. The war, by hindering transit of material from the Cape, has stopped the progress of the railway and produced a temporary stagnation. As

the town stands 4,500 feet above sea level and is on a dry plateau, it is very healthy. Malarial fever, however, may be caught in a severe form in neighbouring districts, and occasionally even in those close to the town. Placed in an open rural district, it might have been supposed that all sorts of farm produce would be plentiful; but such is not the fact. Fresh butter is four shillings a pound, most of the mutton comes from Australia and what is native is goat-flesh; the beef is poor and tough, and tinned meats, fish, &c., are very largely consumed. Apparently almost all luxuries and most of the necessities of life are imported. This state of things will, of course, be only temporary. The promise to agricultural enterprise would appear to be very tempting. The chief drawback is the uncertainty of life amongst domestic animals. The mortality amongst horses is frightful, and as yet the means of preventing these diseases are not understood. Epidemics amongst oxen are also frequent. The value of an ox as a beast of burden is such that no calves or young animals are ever slaughtered. It is only the old and worn out that go to the butcher. It is not possible to exaggerate for this district, or indeed for the whole of South Africa, the value of veterinarian medicine. The increase of wealth and comfort would be enormous if means were discovered for the prevention of "horse sickness" and cattle plagues. The former of these is a very acute malady. The horse may be dead within six hours of his having apparently been in excellent health.

We are told that salted fish from the Cape is not commonly sold in Bulawayo, and our principal informant, who has lived there, is unaware that any leprosy has as yet been observed there.

AFRICAN AFFAIRS OF LITTLE INTEREST A CENTURY AGO.—Of Africa (Central and Southern) Dr. Guthrie, in 1874, writes: "The history of this continent is little known and probably affords no materials which deserve to render it more so." The present century has witnessed a change in our estimate in this matter.

* * *

THE TRANSVAAL NOT SUITED FOR SHEEP.—Sheep will live in but few places north of the Vaal, and the produce of wool is, therefore, very trifling; nor is that of butter great, although it might be made so. The salt employed in curing it is almost entirely the produce of salt pans, which are abundant in some parts of the country, and indeed give its name to the Zoutpansberg.—Sanderson, 1857, *R.G.S.* xxx.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

PANCREATITIS, WITH ESPECIAL REFERENCE TO CHRONIC PANCREATITIS,

*Its Simulation of Cancer of the Pancreas and its Treatment by
Operation, with Illustrative Cases.*

BY A. W. MAYO ROBSON, F.R.C.S.ENG.

July 18, 1900.

(Concluded from page 149.)

Pathological appearances.—Whenever there is obstruction of the common bile-duct by gall-stones, with associated infective cholangitis, the pancreatic duct may be subjected to backward pressure and to the same infective dangers as the liver; hence the association of infective and suppurative inflammation of the pancreatic duct is quite common. If this irritative process is kept up for some time the substance of the pancreas participates in the inflammatory process and an interstitial pancreatitis results. There may be uniform swelling of the gland or only of certain lobules. Effusion into the inter-lobular and into the peri-glandular cellular tissues is associated with proliferation and detachment of the epithelium lining the acini and the tubes, and there is a crowding together of the cells, with an accumulation of inflammatory fluid containing round cells and blood corpuscles in and around the affected parts of the gland, leading to tension. The simple pancreatitis is known by examining the parts of the pancreas less severely affected when death has occurred from abscess or other disease affecting a limited portion of the gland, and I have also seen it in cases of common bile-duct obstruction where the pancreatitis only proved a secondary and not the fatal disease. In the greater number, if not in all cases of obstruction of the common duct where the obstruction is close to the duodenum the pancreatic duct participates in the infective process which usually

follows, and when death occurs it will be found that pus can usually be squeezed from the duct of Wirsung; this has been observed independently by Dr. A. R. Ferguson of Glasgow. If resolution takes place complete recovery may occur or the interstitial effusion may organise and lead to irregular contraction of the tissues and possibly to cirrhosis or chronic interstitial pancreatitis that may either end in diabetes if the whole gland be affected or may lead to pressure on, or distortion of, the common bile-duct and so to chronic jaundice, thus simulating cancer of the head of the pancreas. If, on the other hand, the inflammation be too acute for resolution to occur it may pass on to suppuration which may be general or localised. In all cases of chronic pancreatitis on which I have operated I have found numerous and firm adhesions around the duodenum, pylorus, and hepatic flexure of the colon, all of which have been adherent to the liver and gall-bladder, and on several occasions occlusion of the foramen of Winslow has been found. Where there has not been associated cholelithiasis, the gall-bladder will usually be found distended, and if the obstruction of the common duct be complete it may be very large and filled with mucus. The lymphatic glands usually participate in the inflammatory process and may suppurate. If the patient survive there may be abscesses in the liver, pressure on, or thrombosis of, the splenic vein, enlargement of the spleen, pressure on, or thrombosis of, the portal vein with ascites, or even obstruction to the flow of blood through the vena cava and œdema of the lungs.

Prognosis.—The disease may last for months or even years, and it is not improbable that some of the cases of jaundice persisting for several years and called chronic catarrh of the bile-ducts may be of this nature. If glycosuria supervene it makes the outlook more grave. Increasing weakness and the supervention of hæmorrhagic tendencies usually show the near approach of a fatal termination. Under surgical treatment the prognosis is very favourable, as out of seventeen cases on which I have operated sixteen have recovered, and in nearly every case complete restoration of health has occurred.

TREATMENT OF PANCREATITIS.

In acute infective pancreatitis treatment practically resolves itself into that of peritonitis commencing in the superior abdominal

region. The pain at the outset is so acute as to necessitate the administration of morphia, and the collapse will probably demand stimulants, which on account of the associated vomiting may have to be given by enema. In the early stages the symptoms are so indefinite that the indications for surgical treatment are not clear enough to warrant operation, and until the collapse has passed off no surgical procedure would be justifiable. The simulation of intestinal obstruction will probably lead to efforts to secure an evacuation of the bowels and relief to the distension. In the only case of this kind that I have seen the distension of the upper part of the abdomen was so great and the patient was so obese that any exploration from the front was out of the question, even when the diagnosis was established. A posterior exploration was discussed and would have been made but for the speedy death of the patient. Just as in a perforative or gangrenous appendicitis an early evacuation of the septic matter is necessary to recovery, so in this equally lethal affection an early exploration in the left costo-vertebral angle is demanded, and as it can be performed with very little difficulty I should certainly perform it early in any case I might see in the future, when I should evacuate the septic material and adopt free drainage.

The sub-acute form of pancreatitis is much more amenable to treatment, as the indications are so much more definite and there is more time for careful consideration, and though it has usually only been attacked when an abscess has formed and is manifestly making its way to the surface, yet there is no reason why in some cases surgical treatment should not be adopted at an earlier stage. As in the acute condition, morphia may be required to relieve the paroxysmal pain, and stimulants and food by the rectum to relieve the collapse and support the strength. The distension, if present, may also demand attention and may have to be relieved by lavage of the stomach and turpentine enemata or by the administration of calomel by the mouth. Calomel is also of benefit by acting as an intestinal antiseptic, for which purpose it may be given in small repeated doses or in doses of five grains, followed by a saline aperient. As soon as the constipation is relieved diarrhoea is apt to supervene, when salol and bismuth with small doses of opium may be given. If surgical treatment is decided on, a median incision above the umbilicus will

enable the operator to palpate the pancreas and locate any incipient collection of pus, which if practicable should be evacuated by a posterior incision in the left or right costo-vertebral angle, or failing that possibility the collection of pus may be aspirated and the cavity opened and packed with gauze, which may be brought forward through a large rubber drainage-tube which will in the course of from twenty-four to forty-eight hours establish a track isolated from the general peritoneal cavity. In one case I was able to do this, but the operation was undertaken at too late a stage to be successful, and though the patient lived two or three days afterwards the evacuation of the pus seemed to make very little difference to the general septic condition previously existing and death occurred from increasing debility. The method adopted had, however, been successful from the point of view of drainage, and the track of the gauze and tube was isolated from the general peritoneal cavity. If a definite abscess form and approach the surface in front or in either loin the treatment will be that of incision and drainage as in the case of any other abdominal abscess. Of four cases on which I have operated two recovered completely, one recovered from the operation but died a few weeks later from debility. The fourth case is the one just referred to. The strength must be maintained by careful feeding and the judicious administration of stimulants. It will be necessary to keep a sharp look-out for further collections of pus and for subphrenic abscess or empyema which on recognition will need treatment.

The course and treatment of chronic interstitial pancreatitis is exemplified in the cases related below. Doubtless, in some of these cases the manipulation of the indurated tumour has detached calculi impacted in the gut, but in others the relief of tension as the result of draining the bile-ducts by cholecystotomy or cholecyst-enterostomy has indirectly drained the pancreatic duct and thus has led to a subsidence of the pancreatitis, then to an opening of the common duct by the relief of the tension, and so to a cure of the patient. The simulation of malignant disease of the head of the pancreas by chronic interstitial pancreatitis would make me hesitate to decline operation in any case of distended gall-bladder where the patient was in a condition to bear it, or even in any case of chronic jaundice without distension of the gall-bladder where the general

health was deteriorating, as though it should be recognised that if the disease be really malignant very little good will be done and life may even be shortened or prolonged for a short time, yet if the disease prove to be chronic pancreatitis a real and permanent cure may be brought about. If a calculus be felt imbedded in the head of the pancreas or impacted in the pancreatic duct it may be reached through the second part of the duodenum by laying open the papilla and exploring the duct or by dividing the peritoneum passing between the duodenum and hepatic flexure of the colon and then cutting through the overlying pancreas on the concretion. If the papilla be incised it does not require suture and in the cases in which I have explored the ducts by the duodenal route there has been no hæmorrhage; the anterior duodenal opening requires closing by a mucous and a serous suture. Drainage of the right kidney pouch for from twenty-four hours to forty-eight hours is advisable, though not always necessary, and this is best done by a stab wound at the most dependent part.

For attacking the head of the pancreas or the pancreatic duct a vertical incision should be made through the right rectus and not in the middle line. In all cases of deep jaundice I prescribe chloride of calcium in 20-grain doses thrice daily for twenty-four hours or forty-eight hours before operation and give it in an enema form for twenty-four hours afterwards in 60-grain doses thrice daily.

CASE 2. *Chronic pancreatitis; cholecystotomy; cure.*—A man, aged 45 years, was sent to me on October 25th, 1898, by Dr. J. B. Berry, of Keighley. The patient was very deeply jaundiced and told me that he had lost a stone in weight since the onset of his illness five weeks before. He gave the history of having had attacks of pain referred to the region of the gall-bladder nine years previously, but they were unaccompanied by jaundice and passed off after prolonged treatment. From that time onward he had been free from attacks of pain up to the onset of the present illness five weeks before, when he was suddenly seized with severe pain at the pit of the stomach and became jaundiced. The pain had recurred daily and had been so severe as to necessitate his taking morphia. Dr. Berry noticed a swelling in the region of the gall-bladder a fortnight after the onset of his illness, and there was all

along well-marked tenderness at the epigastrium with gradually increasing enlargement of the liver. The patient's general health rapidly failed and the loss of flesh was well marked. When I saw him he looked pinched and ill, he was very deeply jaundiced, and the urine was loaded with lithates but contained neither albumin nor sugar. There was well-marked tenderness at the epigastrium and a smooth tumour, which was not very tender, in the gall-bladder region; the liver was enlarged and the edge was smooth and could easily be felt an inch below the costal margin. A diagnosis of gall-stones in the common duct was made, and the patient was admitted into the Leeds General Infirmary. The operation was performed on September 27th, 1898. On opening the abdomen numerous adhesions between the gall-bladder and liver and the pylorus, colon, omentum, and duodenum were found. The gall-bladder was slightly distended, but no gall-stones were felt either in it or in the cystic or common duct. There was, however, a hard nodular swelling of the head of the pancreas which at the time was thought to be malignant. In order to give relief the adhesions were detached and the gall-bladder was drained by cholecystotomy. On October 28th I wrote to Dr. Berry telling him that I feared that the disease of the pancreas might be malignant but that there was a possibility of its being a chronic pancreatitis. On November 5th I wrote a letter to this effect: "I am pleased to be able to tell you that your patient has improved very much and the jaundice has nearly disappeared. I hope, therefore, that the tumour of the head of the pancreas may have been inflammatory and not malignant. At the time of operation it occurred to me that it was not quite hard enough for a malignant tumour, but under the circumstances I felt it my duty to give you my suspicions." From that time onwards recovery was uninterrupted and the patient left the hospital with the wound closed within the month. In December, 1899, the patient, at the kind suggestion of Dr. Berry, called to report himself to me. He looked perfectly healthy and had gained over a stone in weight since his return home. He had neither pain nor tenderness and he said that he felt as well as if he had never ailed anything. The scar was firm. The liver was normal, and there was not the slightest tenderness in the epigastrium or in the gall-bladder region.

CASE 3. *Chronic pancreatitis; cholecystotomy; cure.*—The patient was a man, aged 45 years, residing at Pickering. On March 19th, 1898, he was brought to see me by Mr. G. V. Robertson of Pickering, the history being that he had been well up to twelve months before, when he began to have painful attacks at the pit of the stomach ending in vomiting, but not followed by jaundice until an attack on January 1st, 1898, since which time he had been deeply and continuously jaundiced. He had also from that time onwards had ague-like attacks, and two days before seeing me he had had within twenty-four hours three of these seizures, each accompanied by pain. Within a twelvemonth he had lost 2 st. 8 lbs. in weight. On examining him there was some swelling in the gall-bladder region but no tenderness. The liver was a little enlarged but the margins felt smooth. There was decided tenderness in the middle line just above the umbilicus, and on deep pressure the pain was considerable and an indefinite fulness could be felt. The diagnosis of gall-stones in the common duct was made, and an operation was advised. The patient was operated on at a surgical home on March 30th, when the gall-bladder was found to be slightly distended and surrounded by adhesions to the pylorus, duodenum, colon, and omentum. No gall-stones could be discovered, but there was a well-marked swelling of the head and the first two inches of the pancreas which though nodular and irregular was not very hard. This extended further to the right than normal so as to cover in the lower end of the common bile duct. Cholecystotomy was performed. Within twenty-four hours of the operation nearly four pints of very offensive bile were discharged through the tube. A specimen was examined by the Clinical Research Association and their report was as follows: "The bile contains both staphylococci and streptococci, but no bacillus coli communis could be found either under the microscope or in the culture." Fearing that the disease might be malignant and the patient being so extremely weak and ill I gave a poor prognosis, but in a few days I was able to write: "[The patient] is progressing very satisfactorily; though he is still profoundly weak. Bile has appeared in the motions so that the obstruction is evidently overcome. The bowels have been moved naturally and the patient is less deeply jaundiced and looking better generally." On April 5th

I was able to report that he was taking food well and that bile was passing freely in the motions. He had had no recurrence of the shivering attacks. The drainage was continued for fourteen days. On the 20th the patient returned home. The urine was then free from bile and the motions were assuming a natural colour; he was taking food well, gaining flesh, and looking better generally. I still, however, gave a guarded prognosis, though I said that I hoped that the tumour would prove to be inflammatory and not malignant. From that time onward his progress to recovery was extremely rapid. A report I had of his condition from Mr. Robertson a few months later said that he was perfectly well in every respect and that he had fully regained his lost weight. I heard of this patient two years after his operation and he was still in perfectly good health.

CASE 4. *Chronic pancreatitis associated with gall-stones; cholecystotomy; cure.*—On October 20th, 1899, I was asked by Dr. T. C. Squance, of Sunderland, to see a female patient, aged 51 years, who had been suffering for three years from attacks resembling those of gall-stones, each attack being followed by jaundice. During the past fourteen weeks the seizures had been more frequent and severe and jaundice had never quite cleared away before another attack came. She had lost flesh and strength considerably and had vomited from time to time between the attacks. Her digestion was much impaired and there was a want of appetite. She had had no rigors, and had only slight fever at the time of each seizure. The urine contained abundant lithates and a slight trace of albumin, but no sugar. On examination the abdomen showed no manifest enlargement of the liver or gall-bladder, but some tenderness over the gall-bladder and at the epigastrium, where there was an indefinite sense of fulness. An operation was performed on the 23rd, when after detaching numerous adhesions 15 gall-stones were removed from the cystic and common ducts, but as a large nodular mass was occupying the head of the pancreas and partly obstructing the common duct it was deemed advisable to perform cholecyst-enterostomy so as to make a permanent opening between the fundus of the gall-bladder and the duodenum. The tumour gave the impression both to myself, to Dr. F. Macrae, and to Dr.

Squance that it was malignant. Recovery was, however, uninterrupted, the button was passed on the tenth day, the wound healed by first intention, and the patient immediately began to put on flesh. She returned home within the month and has since been perfectly well in every respect. It is now nine months since the operation, and her health, I am informed, is perfect.

CASE 5. *Chronic pancreatitis; cholecystendysis; cure.*—The notes of the following case have been kindly furnished by my friend Mr. Peter MacGregor, of Huddersfield. The patient was a female, aged 51 years, married, and the mother of several healthy children. "Her previous history was unimportant, but for two or three years she had been a dyspeptic and during the past nine months she had been more or less continuously under medical treatment for dyspepsia and recurring attacks of 'cramp in the stomach.' . . . I first saw her on August 19th, 1899, when I got the above history, and a careful physical examination elicited nothing beyond tenderness in the pyloric region. On the 28th, I was telegraphed for to see her, and found her suffering from a severe attack of gall-stone colic. She was seen at intervals from August 28th to October 16th. On the latter date I found her emaciated and in more or less constant pain, with frequent attacks of colic and distress after every particle of food and with much straining and vomiting. Every variety of food had been tried, predigested and otherwise, but all with the same result—constant pain and frequent vomiting. Dr. Williams told me that he could feel a tumour in the pyloric region, but the patient was so very ill and examination caused so much distress I did not satisfy myself of the fact. No jaundice on this date, but previous attacks of colic had been followed by jaundice. On November 25th, the patient came into a nursing home for operation. She was then in constant pain with frequent retching, deeply jaundiced, and a perfect skeleton. Operation (November 28th).—On examining the patient under chloroform a hard, rounded, irregular tumour was found between the umbilicus and the ribs. On opening the abdomen, the stomach, much dilated, was found extensively adherent to the under surface of the liver and on stripping it off, a healthy gall-bladder in the normal position came into view. The right kidney which had been diagnosed as 'floating,'

was examined and the diagnosis verified, but the rounded, hard, irregular mass behind the duodenum appeared to be so undoubtedly a malignant tumour of the pancreas that the abdomen was closed and the friends were informed that the case was malignant and hopeless. After history: The temperature never went above normal; stitches were removed on the ninth day. On the fifth day after operation patient had a chop for dinner. Within a fortnight the jaundice had gone, the appetite rapidly improved, and she went home at the end of three weeks feeling much better, although the four medical men who were present at the operation all felt, and said, she would die within six weeks. On March 15th, 1900, she was plump and fat, ate anything, had had neither pain, retching, nor vomiting since the operation. Her tumour had quite disappeared and her medical man had discharged her as cured many weeks since."

CASE 6. *Chronic pancreatitis; cholecystotomy; cure.*—A woman, aged 35 years, was admitted to the Leeds General Infirmary under the care of Dr. A. G. Barrs, on September 11, 1899, and transferred to me a few days later with the history of having been subject to attacks of spasm in the upper abdominal region for twelve years, the intervals between the seizures having varied from a few days to several months, but of late they had become much more frequent, and during the week before admission she had had four attacks, all severe ones. The seizures began with pain in the epigastrium accompanied by cold sweats and faintness; the pain passed through the mid-scapular and to the right sub-scapular region, and lasted from two to six hours, having to be relieved at times by morphia. Jaundice followed the seizures, and if the attacks recurred frequently it was intensified with each, but if there was a long interval only an icteric tinge remained. Palpation revealed a point of tenderness in the mid-line, one and a half inches above the umbilicus where there was a sense of resistance with an abnormal fulness, but there was no tenderness over the gall-bladder nor could any swelling of the gall-bladder or liver be discovered. On September 21 a vertical incision through the right rectus exposed adherent viscera, and on the separation of the adhesions a thickened gall-bladder was exposed, but there were no gall-stones

in it or in the ducts. The lower part of the common duct was surrounded and overlaid by a well-marked swelling of the pancreas which was harder than usual, but not sufficiently hard to be mistaken for cancer though it was somewhat nodular. Cholecystotomy was performed and drainage was carried out for a fortnight. Recovery was uninterrupted and the patient returned home within the month and she has remained well since.

CASE 7. *Chronic pancreatitis with gall-stone in the common bile-duct ; cholecyst-enterostomy ; relief ; relapse.*—A man, aged 45 years, from Queensbury, was admitted into the Leeds General Infirmary under my care on November 3, 1899, suffering from jaundice with repeated attacks of pain and ague-like seizures. He had been well up to thirteen months before his admission when the attacks began and since their onset he had lost six stone in weight. Jaundice followed the first seizure and persisted, but after each attack of pain it was more intense. He was so weak and ill that it was feared he could not bear an operation. An enlargement of the right lobe of the liver could be felt and on its inner side in the mid-line just above the umbilicus there was another tumour situated behind the stomach. On November 9 an operation was performed on a heated table with the patient enveloped in wool, an injection of 10 minims of solution of strychnia having been previously given. On opening the abdomen an enlargement of the right lobe of the liver was seen, the gall-bladder was found shrunken under adhesions, a floating gall-stone too hard to crush was felt in the common duct, and a hard nodular tumour of the head of the pancreas was discovered. As the latter was thought to be malignant and the patient was extremely feeble choledochotomy was not performed, but the gall-bladder was connected to the duodenum by a Murphy's button in order to give temporary relief to the jaundice, fever, and pain. He had a severe rigor on the night of operation but afterwards progressed satisfactorily and recovered from the operation. The button passed on the twelfth day, and as he had gained some weight and was taking his food well it was thought that the operation was going to be of real benefit to him. The subsequent history of the case was as follows:—On December 8 (a month and a day after operation) he had a feeling of chilliness, and a temperature of 101° F.

followed for two days, his temperature being afterwards normal for twelve days, when he had a rigor and a return of the jaundice ; from this time, although he got up every day, he gradually became weaker, and in January, 1900, he developed bronchitis which ushered in the final scene. At the *post-mortem* examination the peritoneum was found to be free from inflammation and the gall-bladder was found to be connected to the duodenum one and a half inches beyond the pylorus, but the opening had contracted so that it would only admit a fine probe. The common bile-duct was dilated and ulcerated and it contained a gall-stone of the size of a filbert. The liver was considerably enlarged and the right lobe was occupied by an abscess containing thick, slimy muco-pus. The walls of the abscess cavity were ragged and ill defined, and it reached nearly to the surface both in front and behind. It was doubtless the result of the suppurative cholangitis which was present. The pancreas was much indurated about the head, and together with the indurated tissues in the small omentum presented on palpation the sensation of a tumour. On section it presented to the naked eye the appearance of chronic inflammation rather than growth, and on microscopical examination this view was confirmed, there being a great excess of interstitial fibrous tissue, but no sign of cancer.

To add other cases would be tedious to my hearers, but I thought it desirable in bringing forward a subject of this kind to illustrate it by a detailed history of cases that had actually come under my observation. The last case where death occurred from other causes two months after operation is, I think, of importance, as it enabled one to ascertain the after condition of the pancreas which at the time of operation presented the appearance and feel of a considerable tumour. It clearly shows that drainage is capable of relieving the form of pancreatitis which I have described, but that for permanent relief a cholecystotomy is a much safer means than a cholecyst-enterostomy, seeing that the fistula in the latter operation may close before it has completely done its work.

The difference in the results of operations for chronic pancreatitis and cancer of the pancreas is well shown in my own practice. Of seventeen patients on whom I have operated and found chronic pancreatitis to be the obvious disease present, sixteen have recovered, and except in the one case related the patients have been restored

to health; whereas in cancer of the pancreas, of sixteen patients only nine recovered from the operation and of these the prolongation of life was so short as to make me reiterate what I said years ago—that if we can diagnose cancer of the pancreas with certainty, any operative treatment is likely to be useless or harmful. Seeing, however, that sometimes the diagnosis may be doubtful, and that this must often be the case in young and middle-aged subjects, I am of opinion that an exploratory operation should be seriously considered in such cases, as, should the case turn out to be an inflammatory condition of the pancreas and not cancer, I think that I have proved that much may be hoped for by surgical treatment.

ROBBEN ISLAND IN 1898.—The number of lepers in the island on the last day of 1898 was 560, an increase of twenty-eight upon the previous year. Of these 353 were men and 207 women. Eighty men and thirty women had been admitted during the year, and forty-three men and thirty-seven women had died.

The refuse from the leper wards is thrown into the sea and “a large proportion of it redeposited on the beach.”

Besides extra steamers there were in the year 1898 153 “ordinary trips,” carrying upwards of 7,000 passengers.

* * *

CHEAP TRIPS TO ROBBEN ISLAND.—“The Argus Annual and South African Directory for 1893:” “During the year the Institution is visited by thousands of people, to whom the unique life of the island with its many phases is of absorbing interest.”

The “unique life” referred to consists of assemblages of convicts, lunatics, lepers, paupers and dogs in quarantine. The male lepers are allowed to wander over the island, and to associate freely with the thousands of trippers who visit it.

* * *

HOLUB, in his “Seven Years in South Africa,” records that on one occasion when he dined with some chiefs, “ten fish constituted the whole repast.” This was amongst the Marntze, and he says of them that they excel in their methods of dressing fish. Of the Zambesi tribes he records: “A great many fish, after being sun dried, are kept for months and then packed in baskets and sent north for sale.”

CLINICAL LECTURE ON JUNE 5, 1900.

BY WM. EWART, M.D.CANTAB., F.R.C.P.

*Senior Physician to St. George's Hospital and to the Belgrave Hospital for Children.**(Concluded from page 160.)*

THE "CACODYLIC MEDICATION."

THE period of administration is another question. The French authorities originally recommended a *continuance of the drug for very long periods broken by short intermissions*. The tolerance of patients for prolonged courses of the drug, well-attested by experience, is a special feature of the cacodylic medication. In a fair series of cases I have not scrupulously adhered to the proviso for intermissions, and I believe that if the doses be kept moderate a continuous administration may be ventured with due precautions and watching. Nevertheless it will be always safe and often advantageous to rest the patient from the drug for one week out of two or three.

The Indications.

These, as hinted above, extend over a wide range.

The antiseptic properties of arsenic suggest its employment in many toxic conditions.

Its virtues as a nerve tonic again recommend it for all toxic depressions of the nervous system. But they also indicate its use in many forms of nerve atony and failure. The metabolic properties of arsenic appear to be still more manifest in this than in the ordinary form of its administration, a circumstance which opens up for the new remedy an almost unlimited range of usefulness. Indeed, its beneficial influence upon nutrition is probably in all cases strongly favoured by the actions mentioned above; and as a fact those in depressed health, whatever their ailment may be, generally feel refreshed and invigorated very soon after beginning a course of cacodylate. The drug has even been recommended as of much value in cancer, particularly gastric carcinoma.

Cacodylate takes the place of arsenic with increased effect in all those conditions in which arsenic had been regarded as a specific,

particularly in pernicious anæmia, chorea, malaria, Graves's disease, &c.; whilst as a general tonic the limits of its usefulness have probably not yet been reached in practice. I have administered it with great benefit in post-zymotic complications, particularly the nervous affections after influenza. Of these I have exhibited before you to-day several instances, the details of which space will not permit my recording in these pages.

In renal disease I had formerly looked hopefully to arsenic, and I am now administering it again in this new form.

Besides cancer there is another more promising addition to the list of diseases which we may benefit by cacodylic medication; I refer to phthisis. This treatment has been reported upon from abroad as the most favourable medicinal treatment for phthisis hitherto employed; and if we bear in mind the joint antiseptic and tonic effects referred to we may reasonably expect a favourable result. I have myself verified the statement that the tendency to hectic is checked, the cough and expectoration greatly diminished, and the general condition rapidly improved under this method.

In conclusion I trust that in what I have said in favour of this important addition to our armamentarium I have not been carried away beyond the warrant of evidence. It is a satisfaction in these days when compounded drugs are so largely used, to the detriment of our therapeutical conclusions if not of our clinical results, to be able to recommend for your skilled clinical use and observation a remedy pure and uncomplicated, the effects of which can be accurately gauged.

THE AUTOMATIC RESPIRATORY JACKET FOR EMPHYSEMA.

At a previous meeting I discussed with you the means of expanding the lung when it had become collapsed owing to effusion or empyema. The appliance which I now pass round and which was first exhibited at the Medical Society in February last, is an exceedingly simple way of effecting the opposite result, that of diminishing the excessive size of a lung.

As in the other case, the endeavour to reduce the emphysematous distension of the lung has been made by internal or atmospheric methods, particularly by that of systematic expirations into

rarefied air and by the paradoxical treatment of temporary confinement of the patient under an increased atmospheric pressure. Relief is undoubtedly conferred by these methods but I doubt whether any permanent cure has resulted.

The other line of treatment is the application of external or mechanical pressure. This also has long been attempted though not as a continuous treatment, and sundry expiratory exercises have been devised and practised by various authorities. For years I have been striving more and more in that direction, and strangely the fulfilment of this indication of treatment has been arrived at independently within the same year by Mr. Willocks, of Croydon, and by myself,—his being the intermittent plan, mine the continuous. Mr. Willocks' respiratory machine, a most ingenious mechanism, is intended for exercising the patient at intervals. By working pullies with both hands during expiration he actively constricts his own chest, which expands again as he relaxes the pull during inspiration.

The automatic respiratory jacket is much more commonplace. It consists essentially of a backpiece and of frontpieces made of strong inelastic material, which are separated by strips of elastic over the shoulder and down the sides. The straps and buckles which close it in front adjust the pressure. If this be worn continuously night and day each expiration is aided by the elastic, and each inspiration is stimulated by the slight obstacle thrown in its way. The whole theory of the mechanical cure of emphysema is contained in these indications. The practice is illustrated by the relief and the improvement which patients declare they have received when they have worn the jacket even for a short time. Old-standing emphysema would probably never be cured, but I have hopes that this method if applied early in life may be entirely curative, and be the making of lives which otherwise would be lives of comparative disablement.

THE HAMMOCK TREATMENT FOR EMPYEMA.

The use of the hammock was not demonstrated to you when we last met. I am now able to show you its mode of action. I believe there is no more comfortable means of carrying out an awkward requisite, viz., that of lying in a bent position for long

periods. The patient lies on his wounded side which is thus perpetually drained, and the position in the hammock is so arranged that the sound side, which is uppermost, is doubled in, and its costal and abdominal respiration almost abolished. A strictly lateral position may be obtained by shoring up the loins or pelvis with a cushion. The other side is thus made to breathe, which could not be the case on a hard couch; but the respiratory movements are fully permitted by the yielding net, which is almost more like a garment than a support. The hammock has been tried in the case of several juveniles and children and has not been objected to by them.

I need hardly point out that the lowermost or working side of the chest being kept convex, the lips of the wound, and the sinus so long as it persists, tend to be kept patent owing to the greater distance between the ribs.

THE TECHNIQUE OF GELATINE INJECTIONS.

Without entering into much historical detail the method may be described as a direct contribution from physiology to medicine.

Solutions of gelatine—a substance formerly pronounced by Magendie to be useless as a food and as a medicine, are now administered by the mouth as well as subcutaneously. In 1896 Dastre and Floresco ascertained by experiments on dogs that extensive clotting is set up by the intravenous injection of gelatine and that gelatine is a powerful blood coagulant. In 1898 Lancereaux perceived the clinical importance of this property, and in conjunction with Paulesco instituted the gelatine treatment for aneurysm. A sufficient attenuated subcutaneous injection might, he thought, promote remedial coagulation in specially favourable situations, as in the recesses of sacculated aneurysms, whilst not setting up any danger of coagulation within veins. A weak solution (2 per cent.) to be injected at a distance from the aneurysm (carefully avoiding veins) and to be repeated at sufficiently long intervals of time, was found to fulfil these indications, and several cures have been reported. There is a risk in carelessness in the antisepsis or in the operation; and a temporary pyrexia with some pain at the seat of injection is far from uncommon and sometimes abscesses follow.

Lancereaux's original directions were to inject 200 cc. of a 2 per cent. solution of gelatine, and to allow intervals of nine days. Smaller injections and shorter intervals have subsequently been adopted by others. The gelatine solution is kept in sterilized flasks after a course of boiling for fifteen minutes each day for three successive days.

I have used the following apparatus :—

(1) The sterilized flask containing 10 cc. of a sterilized 10 per cent. jelly, and

(2) A glass measure capable of holding 40 to 50 cc. of boiling saline solution which is added to the jelly just before injecting, the flask then needing, of course, to be appropriately cooled.

(3) Meanwhile the double perforation cork with attached india-rubber tubing and injecting needle, which had been kept in a sterilized vessel, is substituted for the aseptic plug in the flask.

(4) An india-rubber handball with cotton-wool plug is connected with the upper air space in the flask, and by this means the fluid is slowly injected.

With this method I have had no trouble in one case ; but individuals differ, and in another case there has been pyrexia, local swelling and an abscess. Indeed, a transient pyrexia and local swelling are rather frequent occurrences.

An alternative to this method is the internal administration of large quantities of gelatine jelly for long periods. This seemed to be of decided benefit in the first case of aneurysm which I treated with gelatine.

Gelatine injections have other uses besides the treatment of aneurysm, particularly as local styptics. It is worth bearing in mind in cases of hæmatemesis that whilst no food is being given by the mouth, gelatine jelly may be ingested, and will then come in direct contact with the bleeding point. It has also been used locally in epistaxis, and by surgeons as a preliminary to operations involving risks of hæmorrhage (as in jaundice, &c.).

THE TECHNIQUE OF SALINE INFUSION.

The apparatus is as simple as the procedure. The only difficulty lies in insuring absolute antisepsis. In some of my infusions I have used an elaborate bottle such as employed for intravenous

saline injection ; but for the large infusions of a quart or upwards an ordinary irrigator being more capacious is more convenient. A steel needle, 4 inches long, of the same bore as the larger sized Pravaz's needle, is connected with it by india-rubber tubing, the whole of which must be carefully sterilized and introduced into the loose tissue at the side of the chest or abdomen or loins. It takes rather less than an hour to infuse a pint through one needle. More good might result from a more rapid administration of the fluid. This was suggested and carried out by O'Neill Kane by using several needles connected with the supply by a branched tube ;—a convenient pocket pattern of the latter by Edwin Hasbrouck is depicted in the *Journal Am. Med. Soc.*, May 19, 1900, p. 1273. Four needles would thus introduce a quart of fluid in less than a quarter of an hour. This is of special value for purposes of resuscitation in severe collapse. Infusion has been resorted to chiefly in such cases, but I believe that its therapeutic use is likely to extend to less urgent conditions. The fluid infused has usually been the normal saline solution (NaCl '09 per cent.). Other salts, such as sodium phosphate, sodium sulphate, sodium acetate and calcium chloride have been used. Sodium saccharate is highly recommended by Dr. Schieding (*Therap. Monats.*, December, 1899, *cf. Epitome, British Medical Journal*, February 3, 1900), in connection with the property which this salt possesses of being decomposed in presence of CO₂ with sodium carbonate and sugar, and of taking up any CO₂ set free in the blood.

A CASE OF CONSTITUTIONAL IODISM WITH SLOW HEART'S ACTION.

This case, that of a groom, aged 23, admitted into St. George's Hospital for acute rheumatic polyarthritis and the bearer of a diastolic aortic murmur, exemplifies a condition little known in this country though common where goitre is endemic abroad and particularly in Switzerland. Jaunin (*Rev. Med. de la Suisse Rom.*, May 20, 1899) has recently reported upon it interesting observations, a brief account of which will be found in the *Epitome of the British Medical Journal*, October 7, 1899. The toxic symptoms in question are distinct from the common iodism affecting the skin and

mucous membranes. Trousseau appears to have been a disbeliever in their independent causation by iodine and to have regarded the cases as a latent form of Graves's disease exacerbated by iodine.

On admission the patient, a red-haired, spare, active-looking man, presented nothing striking in his expression, appearance, or behaviour. I prescribed sodium salicylate, potassium citrate, and a moderate dose of iodide of potassium, with a little free tincture of iodine.

A few days later Mr. Dallaway, who accompanied my round, made the remark as we passed the patient that this must be a case of exophthalmic goitre, and at a glance I perceived that it was thoroughly justified. The patient's aspect had changed, and if we imagine three degrees in the disturbed gaze of Parry's disease, viz. : (1) the staring and glaring, (2) the startled, and (3) the frightened or fierce look, his degree was about the second ; but there was no conspicuous exophthalmos. On examination the thyroid was found to be decidedly fuller than common in spare young men, but there was no prominent goitre. It was also noted that the patient was jerky and nervous, and the eye singularly restless. Strangely, however, instead of an acceleration of the pulse there was almost a condition of bradycardia, the rate being between 70 and 80.

Bradycardia as an unusual complication is not quite unknown. It has lately been described in a case of Parry's disease as the later state of the cardiac affection by Dr. W. Pasteur.¹ In this case the accuracy of our observations was confirmed by those of an intelligent young lady friend of the patient. She independently noticed one week after admission the stare and the restlessness of the eye.

The dose of iodide of potassium and of tincture of iodine was then increased, but no change resulted until after two or three days, when common iodism had supervened causing a slight eruption on the face, some swelling of the eyes, and slight tonsillitis. The effect of this seemed to be to considerably reduce the previous eye symptoms. This change was again noticed by the friend ; and soon after, the administration having been stopped, the patient's ordinary appearance and expression were, according to her statement, restored.

¹ W. Pasteur, M.D., " Graves's Disease with Bradycardia " (*British Medical Journal*, June 2, 1900, p. 1342).

LECTURES ON RESUSCITATION FROM DROWNING, &c.

BY DR. BOWLES.

(The following reports of Dr. Bowles's three lectures are given in abstract.)

DR. BOWLES said that the object of his lectures was to claim more attention to the physics of the upper air passages and their relations in health, accident, and disease, and pointed out that the tendency of modern medicine was to drift more and more exclusively, as in the best days of the Greeks, into the due and proper application of the laws of physics to the wants and derangements of suffering humanity. After pointing out how all our organs of special sense appear to be concerned with the relations of physics to our bodies, he proceeded to give a short history of the experimental work undertaken for Dr. Marshall Hall by Dr. E. Long-Fox, Mr. Hunter, and himself, on the resuscitation of the apparently drowned (*vide* "Marshall on Drowning").

He then demonstrated how clearly all the experiments performed by them proved that the supine position of the body in the dead subject was opposed to the successful application of any form of artificial respiration, inasmuch as a patient, unconscious from drowning or any other cause, was as subject to the laws of gravitation as the dead bodies on which he had experimented. The experiments showed further that the tongue and epiglottis may fall back into the pharynx, fluids or solids already lying there or forced up from the stomach by pressure from without may be inspired, or rather sucked, into the air-passages on the removal of the pressure, and that fluids or matters already in the lungs cannot be extended whilst the patient lies on his back.

On principles based on many experiments disclosing facts such as these, Dr. Marshall Hall published his "Rules of the 'Ready Method,'" which were intended as much for the public as for the profession.

He then showed how, two years later, Dr. Silvester had repeated and confirmed the results of their experiments on the dead body, viz., that compression and relaxation of the chest walls gave rise to a movement of air into and out of the lungs; but he claimed, and rightly claimed, for we had already proved it, that more air could be introduced by extending the arms upwards and further expanding the chest.

Dr. Bowles then continued: The *amount* of air respired is entirely a secondary consideration. People nigh unto death, or in states of syncope, require very little air indeed to keep alive the spark of life; the matter of primary importance is to ensure a free and open airway, to see that there is no obstruction anywhere *en route*, and that nothing is present in the lungs to prevent the air from penetrating freely the finest of the bronchial tubes and reaching the alveoli themselves.

By dissection I have shown how easy it is, in the supine position, for the tongue to fall back into the pharynx and to lie, in comatose or syncopal conditions, with its epiglottis on the posterior wall of the pharynx, and so block the air-way, and for fluids or food to collect and gravitate in the buccal and nasal cavities, and, by our very attempts to save life in this position of the body, for those fluids or solids to be inspired or forced into the tubes and air-cells of the lungs.

In drowning, beyond and above all accidents affecting the respiratory process, is the prominent and palpable fact that the lungs are stuffed and filled with froth, fine foam, and fluid varying in quantity, quality, and consistence according to the circumstances attending the disaster. This is a fact attested by all the leading pathologists of Europe, and about which there can, I think, now be no doubt whatever. Granting this, we see at once that Dr. Silvester, instead of providing for the clearance of the lungs, so directed his experiments as to determine the greatest amount of air which could be introduced into lungs already clear and in a normal condition, a proceeding which, for reasons now obvious to you, did not apply to cases of drowning, and moreover, he introduced the air through an opening directly into the trachea, thus doing away with the protective influence of the glottis in the living body and avoiding the danger of blocked airways in the dead subject under experiment.

However, his "method" was two years newer than ours, which is much to say in days of hurry such as ours, and the assumption that by it more air could be introduced into the chest attracted so much attention and gave rise to so much discussion that the Royal Medical and Chirurgical Society was induced to appoint a committee to adjudicate on the relative merits of the methods of resuscitation then in vogue for the treatment of apnœa and drowning.

That committee, which had for its chairman Dr. C. J. B. Williams, and included such men as Dr. Kirkes, Dr. George Harley, Dr. Burdon Sanderson, Dr. Brown Sequard, Dr. Hyde Salter, Sir Edward Sieveking, and Mr. Savory, was certain to uphold the honour of the great society which such great names represented, and certain also to command the confidence of the life-saving societies and the profession generally.

Their report was read at the Society on July 1, 1862, and published in vol. xlv. of their *Transactions* and in the *Lancet* of July 12. The details of the experiments, although most interesting and instructive, for brevity's sake I omit. I will only deal with some of their conclusions.

The committee first investigated anew the phenomena of apnœa in its least complicated form, viz., when produced by simply depriving the animal of air, and next the subject of drowning, especially as to the period an animal could be submerged and "yet recover without the aid of artificial respiration."

Next the *treatment* of apnœa was considered, and next the experiments on the dead subject and treatment of the apparently drowned, based on these experiments, was suggested, and it is with these that we shall for the moment chiefly concern ourselves.

The report says:—¹These experiments satisfactorily show that the difference between apnœa produced by plugging of the trachæa and that by drowning is not due to submersion, to depression of temperature, or to struggles, seeing that the two animals are placed under similar conditions, with this most important exception—that in the one case a free passage of air out of the lungs, and of water into them, is permitted; in the other the exit of air and the entrance of water

¹ *Med. Chir. Trans.*, vol. xlv., pp. 459-461.

are prevented. There can be no doubt that both these circumstances are concerned in producing the difference in the results of the two experiments ; but that the fact that animals do not recover after so short a period of immersion is mainly due to the entrance of water, and the effects thereby produced, seem to be established by the following considerations :—

The condition of the lungs as revealed by the post-mortem examination.—On examining the lungs of the animals deprived of air by plugging the trachea they were found simply congested ; but in the animals drowned, not only was the congestion much more intense, accompanied with ecchymosed points on the surface and in the substance of the lung, but the air-tubes were completely choked up with a sanious foam, consisting of blood, water, and mucus churned up with the air in the lungs by the respiratory efforts of the animal. The lung substance, too, appeared to be saturated and sodden with water, which, stained slightly with blood, poured out at any point where a section was made. Whether this frothy water, which thus poured out from the cut surfaces, escaped only from minute tubes, or had any of it reached the ultimate air-cells and was poured out from the spongy surface itself, could not well be determined ; it certainly escaped from parts of the cut surface not occupied by air-tubes of visible size. The lung thus sodden with water was heavy (though it floated), doughy, pitted on pressure, and was incapable of collapsing. It is not difficult to understand how by such infarction of the tubes air is debarred from reaching the pulmonary cells ; indeed, the inability of the lungs to collapse on opening the chest is a proof of the obstruction which the froth occupying the air-tubes offers to the transit of air.

The gasping but fruitless attempts at inspiration in drowned animals after removal from the water contrast strongly with the fact that an inspiratory effort, after the removal of the plug in simple apnœa, is almost invariably successful and followed by recovery, and accords with the different conditions discovered by a *post-mortem* examination.

The conclusion thus arrived at is confirmed by the great length of time that the heart continues to act after submersion.

The entire dependence of the early fatal issue in apnœa by drowning upon the patulous condition of the windpipe, and its

results, was strikingly shown in another way by the following experiments :—

Experiment 40.—A strong dog had its windpipe plugged in the usual manner, and was then drowned, *i.e.*, submerged in water, for four minutes; three-quarters of a minute after its release it breathed, and in four minutes had recovered fully.

Experiment 41.—A large dog was treated in exactly the same way and with exactly the same result—perfect and immediate recovery after four minutes' submersion.

Experiment 42.—A medium-sized dog was plugged and submerged, just as the above. The result was just the same; after four minutes, perfect recovery.

Here, then, are three cases of recovery after a four minutes' apnoea, in which the dogs were in every respect under the conditions of drowned animals, except that their windpipes were plugged. These experiments form an admirable contrast to the cases of mere drowning without plugging.

Seeing that the entrance of water into the lungs and the formation of foam by its admixture with the air in the bronchial tubes, together with the mucus of their surface, is due to the violent respiratory efforts during the first minute of submersion, it appeared that if these efforts could by any means be diminished the result might be somewhat modified. With the view of testing the validity of this opinion, experiments were performed under chloroform, and such was found to be the case.

(1) The report goes on to say¹:—As regards the position of the tongue and its influence in impeding the entrance of air, it was found that in the dead body this organ is apt to offer great obstruction to inspiration by falling back into the pharynx, and closing the laryngeal aperture.

The committee confirmed, as you see, in every detail the results of our experiments and of those of Dr. Silvester. We were all in accord up to a certain point, but the committee went further, and again demonstrated that which we, in our experiments, had taken for granted, *viz.*, that in drowning we are not dealing with healthy lungs, but with lungs, as the chairman repeated, “choked with frothy fluid, and that fluid more or less bloody.”

¹ *Med. Chir. Trans.*, vol. xlv., p. 490.

These were the words of the chairman, and Dr. Edward Smith, speaking on the report (*Lancet*, July 12, 1862, "adverted to the importance of the quantity of bloody water found in the lungs of the dogs drowned, and explained that the water would be introduced from the bronchi into the blood-vessels by endosmosis, and this would cause swelling and bursting of the blood corpuscles after the circulation had been greatly retarded or arrested, and would also cause rupture of the capillaries, or the attenuated blood would pass through the walls by exosmosis, and thus appear in the bronchi." Further on he said :—"It has been shown by the report that in cases of phthisis, where the lung capacity was greatly reduced, the effect of the two methods (the Marshall Hall and Silvester) was precisely the same. Such would also probably be the case with drowned persons, in whom the lungs were full of water, which offered a great obstacle to the introduction of air, and in this condition the committee had not made any experiments."

It was in reference to the practical object in the appointment of the committee that the report failed. The committee had not proved that any one of their inquiries was applicable to the drowned human subject. The time during which a man could be immersed in water and recover could not be proved by experiments on dogs, and the committee themselves had shown that all their plans for the restoration of drowned dogs had failed. The committee had, in one part of the report, disclaimed any intention to say how far the Silvester method was fitted for the restoration of the drowned; and yet in their recommendations they advise the use of this method almost exclusively, without having in any experiment tried it under these conditions. The recommendation to place the body prone and allow fluid to run out of the mouth was an old recommendation; but they had inferred, and not proved, its value, and that only from experiments on drowned dogs which they could not resuscitate. The experiments on dogs had shown that neither hot nor cold water alone had any value as restorative agents, but that the alternative of the two was somewhat useful; but this alternative had not been recommended for man. Hence he (Dr. Smith) regarded this report as but the commencement of the inquiry—a labour which had elicited important facts fitted to be employed in further researches; but as to the great object had in view the appointment of the com-

mittee—the scientific determination of the best method for restoring drowned men—he thought that it altogether failed. He urged the importance of the same gentlemen continuing the inquiry, and of making experiments under the conditions in which the knowledge must be applied, viz., upon men after immersion. He thought that the results of the present inquiry proved that for the observation of defined facts with known methods of inquiry, or with slight modifications of known methods, the appointment of committees would ensure the work being done at a given time and with authority, provided the names of the observers were appended to each observation; but for the solution of complex questions (as all questions of practice are), committees would fail, since the essence of such an inquiry is the invention of a new method, and new methods can never be devised to order, but only through long-continued thought, without the investigator being commonly able to trace the steps which led him to the result. Hence the last series of questions must always be solved as heretofore by individuals, and that not in any particular country, age, or time, but when the happy idea has occurred to an inquirer. Such he believed to be the experience of those who had been extensively engaged in scientific research. He attached great value to the facts contained in the report.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY SEYMOUR TAYLOR, M.D., F.R.C.P.

I.—*A Case of Pulmonary Phthisis with Emphysema.*

THE patient (Robert M.), a vocalist, aged 40, was sent here by Dr. Hebert with a history of cough and pain under the right clavicle of two years' duration. Further questioning elicited the fact that he had had winter cough with dyspnœa for some years before the above symptoms supervened, and that he had contracted syphilis about nine years ago. The patient's mother died, aged 34, of phthisis, but his father was living and healthy.

Physical examination of the chest showed that it was distinctly of the emphysematous type, the movements during inspiration and expiration being limited, whilst the costal arch was widened. The area of cardiac dulness was diminished, as was that of the liver and spleen, owing to dilated and overlapping lungs. The percussion note at the left apex was hyper-resonant, and there was a sense of elasticity imparted to the fingers when they struck the chest wall in this region.

The upper lobe of the right lung, however, from supraclavicular region to the level of the fourth rib was dull and resistant, and over this area the vocal phenomena were increased, and there was easy conveyance of the whispered voice (pectriloquy). Auscultation revealed the presence, during inspiration and expiration, of moist sounds (crepitant râles) which, larger and coarser over the apex of the lung, diminished and became finer as the stethoscope passed downwards, until they finally disappeared at about the level of the fifth rib. He expectorated muco-purulent sputa, he was losing flesh, and occasionally complained of night sweats. The

physical signs of apical dulness, with large moist sounds and pectiloquy, are sufficient grounds on which to base our diagnosis of phthisis, although this will finally be put to the test by a microscopical examination of the stained expectoration. The emphysema, I take it, is an accidental complication, possibly brought about by his occupation.

The treatment which I suggest is that he should have some linctus or lozenge containing opium in order to relieve his cough, and that he should have as abundant supply of fresh air and sunshine and food as his means and other circumstances will allow.

II.—*A Case of Renal Disease.*

M. S., a plumber, aged 25, has been sent up to the Polyclinic by our friend Dr. Daniell, with the following history:—

Three and a half years ago he had pain in the right testicle, which was looked upon as being “neuralgia of the testicle,” and probably it was. A few weeks later he had all the symptoms of renal colic on the right side, which subsided in a few hours, but was followed by retention of the urine. This attack passed off, and six months later the symptoms were renewed, when he consulted another medical man, who diagnosed the case as one of appendicitis. About twelve months ago he was seen by Dr. Washbourn, one of the physicians to Guy’s Hospital, who suspected tuberculous kidney. The urine was examined by the Clinical Research Association at the time, but there was nothing in their report to indicate the confirmation of this diagnosis. Yet more recently, about eight months ago, the patient was “skiagraphed” to help to prove or negative the diagnosis of a possible impacted calculus in the ureter. This gave no definite shadow of a stone. Two months ago, that is to say last July, he had another severe attack of pain in the right iliac fossa and lumbar region lasting for a few hours. Although frequently examined by Dr. Daniell there had never been noticed any swelling or undue resistance in the parts affected by the pain. The patient has been carefully dieted and the bowels have acted regularly. Such is the brief history of our patient.

Now, I take it, that the primary source of his disease or trouble is in or around the right kidney. The neuralgia of the right testicle,

in default of any enlargement or obvious disease of that gland—and he has none of these signs—can only have been indicative of some irritation of nerve-trunks emerging from the lumbar cord. For, as you know, the testicle is an emigrant, but brings with it, as it descends into the scrotum, its vascular, its nervous, and its attendant lymphatic supplies. That he has renal trouble, on the other hand, is indisputable from the fact that the urine which we have obtained from him is of specific gravity 1024, of acid reaction, and that it contains a large amount of albumen, but no blood. The question therefore arises, what is the trouble in or around the kidney? Tuberculous disease, although not impossible, is, from a clinical point of view, improbable by reason of his well-nourished frame and the absence of manifestations of tubercular disease in the lung or elsewhere. I may add that his temperature is normal. This latter symptom is important, as it almost of necessity excludes also the possibility of there being nephritic or perinephritic abscess.

The diagnosis is obscure, but the presence of long continued pain without emaciation, accompanied by albuminuria, strongly suggests to my mind that he has a renal calculus, but a more careful microscopic examination of the urine will be requisite before a decided diagnosis can be made. The presence of blood in small quantities, taken with his other symptoms, would, to my mind, be conclusive that he has calculus. On the other hand, I would warn you not to draw any hasty conclusion that a patient with these symptoms has a malignant disease, if the microscope merely shows an indefinite quantity of various-shaped epithelial cells; for you must remember that the epithelium of the renal tract is varied in its character, and may resemble cells of cancerous growth. It is only when such epithelial cells are shed in clumps or masses that the diagnosis of malignant disease of the kidney and urinary passages becomes more than suspicious. His occupation at first suggested that he might be suffering from lead colic; but the pain is entirely right-sided, the bowels act regularly, and he has no blue line on the gums. The right groin is free from any signs suggestive of disease of the appendix. In conclusion, I should advise that this patient be kept in bed for a fortnight or so; that his urine should be carefully examined microscopically from day to day, and I think it would be as well that a sound should be passed into the bladder, in order that

this viscus may be thoroughly searched for a calculus that may have possibly come down from above.

III.—*A Case of Rheumatoid Arthritis.*

Z. W., aged 43, married. She has had six children, but the catamenia have ceased for the last nine years. She now complains of severe pains in the joints of her arms and legs. These pains have existed with varying intensity for ten or twelve years. I must add that she has suffered from menorrhagia and dysmenorrhœa during her child-bearing years. Now, the appearance of the patient is very characteristic. She is a thin, worn, neurotic woman with stiffened joints, both large and small, with partial dislocation of some of the joints of the fingers and toes, a glossy skin over the hands, forearms, feet and legs. The cuticle over the hands and feet is dense, hard, and resistant, resembling the condition known as scleroderma. The muscles of the forearms are somewhat wasted, but this condition is greatly accentuated in the interossei of the hands. I must add that the joints generally are stiff and actually painful on movement.

Now, here is a typical example of a case about which there would be much controversy as regards diagnosis. Mr. Hutchinson, if I read him rightly, contends that, given a patient with an hereditary tendency to arthritic disease—and I may say that this patient has that hereditary tendency—she may, according to her mode of life and her surroundings, become gouty or rheumatic, or may take a middle course in which the two diseases are commingled and produce what is known to the public and to the profession also as “rheumatic gout.” But Charcot and Ord regard these cases in a different light, and I must say that there are good grounds for their opinion. Briefly it is this: that some irritation of pelvic organs, such as this woman has suffered from for years, is passed up by the sensory nerves to the spinal cord, where a definite lesion is produced in the gray matter; which lesion is reflected in the skin and its appendages and in the joints. For, as you must know, recent researches into the functions of the gray matter of the cord and its various groups of multipolar cells prove that they exert a trophic influence upon the skin and the viscera, upon the motor nerves and muscles, and on the joints. At the very onset of our demonstration

I drew your attention to these clinical symptoms. Therefore, I take it, that whatever name may be given to this disease, the patient has undoubtedly an irritative lesion of great extent in the gray matter of the cord, and especially its anterior cornual group of cells.

The prognosis, so far as recovery, is not very good, but much can be done for the relief of our patient. I would suggest hot fomentations every night to the whole length of the spinal cord, that she obtain as much rest as possible, that she should have a liberal diet, and that arsenic should be given freely, beginning with four drops of the solution three times a day and gradually increasing the dose up to ten or twelve drops. Frequently these patients obtain relief when the menopause arrives, but I apprehend in our patient, seeing that the catemenia have been absent now for nine years, that she has already arrived at this epoch.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. JONATHAN HUTCHINSON.

(Continued from page 170.)

The cases which were brought for consultation on September 6 were the following :—

XXII.—*Exfoliative Dermatitis of Palms and Soles in association with Psoriasis Patches on Elbows.*

THE subject of this case was a very healthy old man of 73. He was brought by Mr. Hitchins. The whole palmar aspects of both hands, to the ends of the digits and over the fronts of wrists, were involved in a dry white scaly form of dermatitis. The margin on front of wrist was abrupt. The backs of the digits were also involved. The soles of the feet were in a similar condition. On the fronts of the ankles and on the elbows were circumscribed patches symmetrically placed, which were not to be distinguished from common psoriasis. Mr. Hitchins informed us that some years ago he had effected great improvement by a mercurial course,

but the condition had relapsed. There was a history of a venereal sore at the age of 20, but none of secondary symptoms. The man had enjoyed excellent health through a long life, and was the father of several healthy children.

I remarked that we might, I thought, in the first place, put wholly aside the suggestion of syphilis. The fact that mercury had proved beneficial went for nothing, for mercury pushed to salivation was the best cure for psoriasis palmaris, whether specific or not. It seemed very doubtful if the man had ever had syphilis, and even supposing that he had, a healthy life of forty years had intervened. As regards the form of dermatitis it was in itself more like cases of non-specific origin than those which are syphilitic. The great extent of the area involved (literally the whole hand) and the extensions on the backs of the fingers were features of distinction. I mentioned several cases exactly like the present one in which there was no evidence of syphilis, and of two of these portraits were produced. Lastly, we had, I remarked, the patches of psoriasis on the elbows. These were conclusive in support of the non-syphilitic diagnosis, and were also most valuable evidence as to the real nature of the malady. They seemed to connect it with common psoriasis itself—not that the case was precisely one of psoriasis, for it was very infrequent that the palms and soles suffered when psoriasis was developed on the body and limbs; whilst we had many cases in which the palms and soles were affected in which no patches occurred on other parts. In fact, the combination observed in the present case was a very infrequent one, and hence its great value as proof of a relationship which might otherwise have been doubted. I mentioned the fact that in pityriasis rubra or dermatitis universalis the palms, soles, and digits usually suffered severely, conditions being produced very like what we had before us, and further, that in one instance in which a woman had for long had her hands in this condition and had been cured, she subsequently had a generalised attack of eczema. I also referred to the occasional occurrence of lichen planus on the body with psoriasis palmaris. These facts, I suggested, taken together went to imply that all these maladies were related. They were alike in that they usually occurred to persons in good health, that they were symmetrical, not attended by any failure of health, and very prone to relapse after

cure. As to cure, the free use of mercury or arsenic would often seem beneficial, but in either case the drug must be pushed freely, and seldom were any evidences of improvement produced until the symptoms of drug-poisoning were produced. In one case small doses of opium had cured after other remedies had failed.

Our next case was one of—

XXIII.—*Tumour in the Breast.*

The patient, a woman of 70, had a lump as big as a hen's egg in the outer part of her left breast. It was reported to have grown in a month. There was no retraction of nipple, no gland disease, and no family history. I remarked that, although we need not accept literally the duration that was alleged, yet we might safely assume that it had grown rapidly, and upon that fact base an argument in favour of the necessity for operation. There was nothing in the patient's age to forbid it, and I strongly advised immediate and complete removal of the whole breast, preceded as usual by an incision into the lump in order to establish the diagnosis.

XXIV.—*A Case of Herpes Zoster, affecting an Upper Extremity and extending to the Fingers.*

The subject of this case was an old man of 75. The eruption was in its third week, and most of the vesicles, which had been numerous but very small, had dried up. These were represented by thin crusts of mere red points. Their grouping was the chief feature of interest. They involved on the hand and forearm the district of the ulnar nerve, almost wholly exempting the thumb and fore-finger, but extending outside the ulnar territory to the whole palm and to the middle finger. Above the elbow a long group extended over the front of the biceps. There were none on the back or chest. The old man complained bitterly of the pain he had had in his armpit and in the arms generally, and of burning in the ends of the fingers.

I commented upon the rarity with which the hands and feet are involved in herpetic eruptions as compared with the frequency of their occurrence on the trunk and on the proximal parts of the limbs. I also asked attention to the very slightly vesicular form of the eruption.

Herpes should be defined as a neuritis often attended by an eruption. We must not regard the latter as an essential of the disease. Probably many examples of herpetic neuritis occur without eruption or with only an abortive one. Pain or numbness in a certain nerve region might be the only symptom produced. In the present instance the pain had been quite out of proportion to the amount of eruption, and it had been experienced chiefly in parts in which there were no spots or very few—the armpit and the finger ends.

XXV.—*Obscure Head Symptoms in an Infant.*

The infant, a girl of 6 months, looked somewhat puny, but showed no definite objective symptoms. She rolled her head backwards, took but little notice of things, was very voracious, and very fretful. She was bottle-fed. The mother thought that she could both see and hear, but admitted that as regards mental development she appeared to be going backward. No evidences of inherited syphilis were present. The pupils were small, but acted to light. There had been neither sickness nor diarrhoea. The mother had lost her first-born child at its birth, and this was her second. We were obliged to leave the diagnosis uncertain, but it seemed not improbable that idiocy would result. The child was said to have been puny at birth, and to have improved rather than otherwise since.

XXVI.—*Indurations in the Skin and Subcutaneous Tissue in association with Diffuse Morphœa.*

The woman whose case is in part recorded at page 169, attended again, and I avail myself of this opportunity to supply an important omission. I forgot to mention that, in addition to the patches and nodules of induration which occur symmetrically on her thighs, she has been the subject of a minor form of acroteric or diffuse morphœa of her hands and face. At one time, Mr. Hitchins informs me, her digits were hard and liable to Raynaud's phenomena and the skin of her cheeks and nose was also indurated. During the last eighteen months she has taken, on my prescription, a pill containing two grains of quinine and a quarter of a grain of opium three times a day. This has been regularly continued, and with the greatest possible

benefit to her health. Her liability to Raynaud's phenomena in her hands has almost ceased, and her cheeks have become more supple. She states that she has taken the pill regularly and would not like to leave it off.

The addition of this fact is of importance, since it helps us to connect the subcutaneous induration on the thighs with morphœa. This connection was suggested as a possibility before.

It is necessary also to correct an error in the previous narrative. I stated that there was a history of gout in the family, but this the woman now denies and says she meant her husband's family. It is often very difficult to get at the real facts in such matters, but having regard to the denial of gout and the proved existence of morphœa tendencies, I think we may safely regard the case as proving that these subcutaneous indurations are really a manifestation of the latter malady.

Kaem *P*
XXVII.—*Pathological Dislocation at Hip Joint.* *Possibly detachment of Epiphysis.*
On x var

Our last patient was a young man whose case will be published hereafter more fully. For the present it may be stated that we demonstrated for the third time that all the symptoms of a fracture of the neck of the right femur were present. The limb was everted and shortened to the extent of nearly two inches. Flexure could be accomplished to right angles with the pelvis. The patient, a youth of 19, can now walk freely and experiences no pain. The pelvis is undergoing compensatory displacement, being higher on the sound side. No symptoms of disease remain. The diagnosis is; a pathological detachment of the epiphysis, for the head of the bone cannot be found dislocated. There is no history of injury, and although for some months the lad was unable to walk about, he was never confined to bed and no abscess ever threatened. The case is one of the utmost interest. We again measured the limb and verified our former observations, and another photograph was taken.

Cases on September 20.

The cases which we had before us on September 20, were the following:—

- (1) Morphœa of the herpetiform type in a lad (my own patient).

- (2) Epispadias with ectopia vesicæ (Dr. Dixon).
- (3) Large congenital tumour in an infant (Dr. Dixon).
- (4) Recovery from brain-syphilis with hemiplegia and prolonged aphasia (Mr. Milburn).
- (5) Abscess in connection with a hernia (Dr. Fletcher).
- (6) Very extensive lupus of the exfoliative type after syphilis (Mr. Hitchins).
- (7) Impetigo contagiosa after vaccination.

A report of the comments made on the more important of these cases will be given in our next number.

REPORTS OF MEETINGS OF COMMITTEES OF INVESTIGATION.

On Leprosy as seen in London.

THE standing Committee on the subject of LEPROSY has held several meetings, and important discussions have taken place. Dr. Radcliffe Crocker is the Chairman of this Committee, and the subject at present under investigation is the experience of London consultants in reference to the cases imported from abroad into England. Detailed statements of personal experience, comprising in a total nearly a hundred cases, have been made by Dr. Radcliffe Crocker, Dr. Abraham and Mr. Hutchinson, and the Committee hopes to receive further contributions from Dr. Liveing, Mr. Malcolm Morris, Dr. Thin, Dr. Colcott Fox, and others.

As yet no single case has been mentioned in which anything suggestive of contagion has occurred in England, although precautions have for the most part been wholly neglected. Nor has any observer related an instance in which both husband and wife were affected, or indeed more than one in a family, with perhaps one exception in which brothers suffered. Numerous cases of more or less complete recovery have been mentioned.

We now publish Dr. Radcliffe Crocker's report, and shall give others in due course.

Dr. Radcliffe Crocker opened the discussion by giving an analysis of twenty-seven cases of leprosy which had come under his own observation.

All the cases were imported, all but one (a Hindoo) were white people. One was a Russian Jewess; three were South Americans; the rest were either born in England or in English colonies and of English descent. As might be expected, the males predominate as three to one.

The disease had been contracted in the following places:—

East.—China, Malacca Straits, India, Ceylon, Singapore, and Australia.

West.—West Indies, British Guiana, Venezuela, Paraguay, and Brazil.

Europe.—Turkey and Riga.

On the whole, the tuberculate were more numerous than the maculate, but in private practice there was a slight predominance of the maculate. One in four and a half were of the mixed form.

The ages varied from 7 to 63 years. The longest time of incubation ascertainable with certainty was seven years at least. The disease set in abruptly seven years after the patient, a girl of 14, left Ceylon with symptoms which led to the diagnosis of rheumatic fever. Another case began with what was supposed to be ague, but the great majority began insidiously or, at all events, without constitutional symptoms. One patient had a general erythematous outbreak the day after a sunburn of the shoulder in the tropics, but did not feel ill, and his features subsequently thickened so gradually that it was only the remarks of his friends which drew his attention to his altered appearance.

Another case began with “mottling” of the skin, and no other symptoms until eighteen months later, when the hands and feet swelled and tubercles developed. Nevertheless he had been passed for life insurance. A mixed case began with severe itching between the toes and some red raised patches and papules on the body, but no general symptoms. Another began with severe shooting pains along the peroneal and ulnar nerves. Many of the maculate cases had no other symptoms for years beyond rings of brownish-red hue, with more or less anæsthesia inside the rings, though sometimes it was very slight in degree. In the earlier stage there was sometimes

hyperæsthesia for a short time on the patches. Sometimes the rings were unilateral for a long period.

In his experience children did badly; the disease was often steadily progressive and the duration therefore was much shortened as compared to adults, but even children live eight to ten years in some cases. Even in the tuberculated form the course was often very slow, with long intermissions of activity. One case was of fifteen years' duration and had been under the author's care for eleven years, and except that he was blind from chronic iridocyclitis, said that he felt as well as ever he did. His face was, however, considerably disfigured in the last two years, having improved up to that time. Of late years he had had recurrent febrile attacks, which always indicate a downward course.

In a maculate case the disease was of eleven years' duration, and red and brown rings, with more or less anæsthesia inside them, were the only symptoms. These rings in many cases disappear spontaneously or as the result of treatment. They may come out very suddenly or insidiously. In one case the first sign was that the skin affected was paler and got bluish on bathing, and there was scarcely any change for eighteen months, when the application of an irritant made them come out prominently.

In two cases there was a possibility that it was contracted by connection with native women. Two cases had lived in the same house as a leper, but were not closely associated. One patient admitted that he had frequented the native haunts in India in a way unusual for Europeans. One had had an under-servant in his house some years before who was sent away as a tuberculated leper.

A few slight macular cases got well spontaneously. A well-marked case was quite cured apparently by chaulmoogra oil, of which he took 500 drops a day for some time, but he could only take it by living high up in the Andes. Improvement began soon after he attained the big dose. He knew of no cure of a marked tubercular case except the one recorded by Mr. Hutchinson. He had, however, found that by means of intramuscular injections of mercury he could remove most of the infiltration and thus improve the patient's appearance, and also the mental apathy and depression disappeared; but he did not now think that the injections killed the bacilli but probably, as in syphilis, they might make the soil less favourable for

their development and maintenance. He gave the injections intermittently now—giving them for three months and then waiting two months and resuming. He thought chaulmoogra oil was an important aid when the patient could be taught to take adequate doses, *i.e.*, at least 100 minims a day, but anything under 50 minims was of no appreciable value.

He had no opinion of gurjun oil either internally or externally, but oil inunctions were always grateful to the leper, and he had found olive oil answer the purpose, and thought that oil frictions favoured the absorption of nodules and infiltrations.

Both salicin and quinine were of value during the recurrent febrile attacks, but he had never been able to observe any result in chronic cases. Possibly, however, if given while mercurial injections were being used, they might destroy the liberated bacilli. A temperate climate was probably a favourable influence, and undoubtedly a leper should not continue to live where the disease is endemic.

RECENT EXPERIMENTS AS TO MALARIA.

A Leader from "The Times" of September 22.

WE reprint in full a very excellent leader which appeared in the *Times* of last week, reviewing the recent experimental gains on this most important topic. Although appearing in a non-professional paper, it is evidently written by a well-informed authority on the subject, and is well worthy of more than a merely ephemeral record, however widely circulated.

The accumulating evidence that the whole of the forms of intermittent fever which have been popularly called "malarial," and which, from a very early period, have been erroneously attributed to the influence of noxious emanations proceeding from the earth, are in reality communicated to mankind in no other way than by the bites of certain species of mosquitoes, which have previously been infected by feeding on a fever patient, has for some time past been sufficient to carry conviction to the minds of all who are accustomed to the conduct of scientific inquiry. These, however, constitute but a small minority of the persons to the prosecution of whose business or pleasure intermittent fevers constitute a formidable or insuperable obstacle, and who may easily be led, by the incredulity which is the natural

offspring of ignorance, to neglect precautions which, if properly observed, would secure to them complete immunity from illnesses of the indicated description. It has therefore been thought desirable to institute a series of experiments of such a character as to remove from the public mind all possible doubt upon the questions at issue; and these experiments have now been brought to a satisfactory conclusion. Acting under the advice of Dr. Manson and the Council of the London School of Tropical Medicine, Mr. Chamberlain consented to provide a mosquito-proof hut which might be set up in the worst region of the Roman Campagna, and the Council undertook to find two skilled observers who, with necessary servants, would occupy it from May to October of the present year—that is, during the whole of the so-called “malarial” season. The hut was furnished with a wire gauze door and window screens, and with other devices to render it mosquito proof. The occupants were to be at liberty to go where they liked during the day, as mosquitoes feed chiefly during the night, but from an hour before sunset to an hour after sunrise they were to remain in the hut. A spot was selected near Ostia, where to sleep for a single night was regarded by the Romans as tantamount to contracting malarial fever of a virulent type; and Drs. Sambon and Low, of the School of Tropical Medicine, together with Signor Terzi, an Italian artist, and two Italian servants, duly entered upon their residence. Inasmuch as October has not yet arrived, the experiment, even if complete, is not yet finished; but up to the present time the tenants remain in perfect health. They were visited on the 12th inst. by Professor Grassi, accompanied by Drs. Noè and Foa, his assistants, by Professor Rossi, of Cagliari, and by Dr. Zupitza, assistant to Professor Nocht at the Hamburg School of Tropical Medicine, and were carefully inspected. The result was the following telegram to Dr. Manson:—“Assembled in British mosquito-proof hut, and having verified perfect health of experimenters amidst malaria-stricken inhabitants, Italian doctors salute Manson, who first formulated mosquito-malarial theory.—GRASSI.” It may, therefore, be taken as proved that intermittent fever can be avoided by avoiding mosquito bites, and that an active out-door life, with perfect immunity from fever, is compatible with continued residence in a badly-infected district, provided that protection be secured by returning to a mosquito-proof house before sunset.

The next step in the demonstration was to show that intermittent fever would be contracted by a perfectly healthy person, who had never entered a “malarious” locality, if he were bitten by mosquitoes brought from thence. Mosquitoes raised from the egg in a laboratory, and which had had no previous opportunity of obtaining fever parasites, were to be fed in Rome on patients in whose blood the parasites of tertian ague were ascertained by the microscope to be present. The insects were then to be sent to London and fed on vegetable juices until proper time had been given for the fever germs to reach their venom glands. They were then to be liberated in a small mosquito house in which one or more healthy Englishmen who had never left this country were to sleep. In pursuance of this programme three batches of anopheles were fed in Rome by Dr. Bastianelli on three separate patients suffering from tertian fever, and were forwarded in cages to the London School of Tropical Medicine. Dr. Manson’s son, Mr. P. T. Manson, consented to be the subject of the experiment, and was bitten every second day by the insects until they died, usually about ten days after their arrival in London. The first batch was fed in London in the first and second week of July, the second at the end of August, and the last during the second week of September. Mr. Manson remained in perfect health until the morning of the 13th inst., when he was suddenly attacked by headache, bone-ache, lassitude, and loss of

appetite, with rise of temperature to 102°. On the 15th there was a distinct intermission during the forenoon. High fever, with temperature of 104°, set in about 4 p.m., with delirium, and was relieved during the night by profuse diaphoresis. The same series of events recurred on the 16th, and on the morning of the 17th tertian parasites were found in his blood. The nature of the illness was verified, and the parasites were seen, not only by Dr. Manson himself, but by several other competent observers, among whom were Dr. Frederic Taylor, Mr. Watson Cheyne, F.R.S., Lieutenant-Colonel Baker, I.M.S., Dr. Galloway, Mr. James Cantlie, and Dr. Oswald Browne. While, therefore, the first experiment shows that immunity from fever will be secured by the effective exclusion of infected mosquitoes during their feeding time, the second shows that fever will be communicated in the absence of any other possible cause for its occurrence by suffering them to feed upon a healthy person in this country. The delay in the appearance of symptoms in Mr. Manson's case may have been due either to the condition of the insects which first attacked him or to the need for some lapse of time after the parasites were introduced into his blood before they had multiplied sufficiently to become effective causes of fever. The public will be glad to hear that Mr. Manson is not likely to sustain any permanent injury or inconvenience from his plucky experiment. The tertian parasite is not virulent, and is easily killed by quinine. This has been administered, and Mr. Manson has had no subsequent recurrence of fever, although a few parasites can still be detected in his blood.

The practical outcome of these experiments promises to be of great public advantage. The first consequence of them, in all probability, will be the restoration of the Roman Campagna to the healthiness and the fertility which it once possessed. The King and Queen of Italy have taken great interest in the hut experiment, and have been kept fully informed of all that has been done. The experience of the English fen districts shows that the ague-carrying anopheles disappears before drainage and cultivation; and when it has once been shown that cultivation can be securely practised under a condition no more onerous than that of sleeping in a mosquito-proof hut, there can be no doubt that Italian capital and enterprise will speedily avail themselves of the great opportunity which will be afforded them, and that a tract of land which roughly measures ninety miles by forty, and which is scarcely used except for autumn pasture, will be reclaimed for all the purposes to which it can be applied. Prominent among these, in all probability, the ground being mainly volcanic, will be the growth of the vine. Nor is it less important, especially to ourselves, that the greatest perils of settlement on the west coast of Africa will, in all probability, soon cease to be formidable, so that the country will be rendered fully accessible to the enterprise of English settlers and merchants. The one condition is, of course, that those interested must exercise common sense, and suffer themselves to be guided by knowledge rather than by the ignorance of persons whose single claim to be counsellors rests upon the plea that they have "been there." There can be no reasonable expectation, within any moderate limit of time, of either freeing Africa from the anopheles or of destroying the parasite in the blood of native children, who, in a way not yet completely understood, appear to acquire some sort of immunity from its worst effects, and who are the sources from which newly-hatched mosquitoes seem chiefly to derive their own supplies. For some years to come, at least, nocturnal protection will be the only means by which safety can be assured to Europeans; and those who have business in the country must learn to render this protection effectual. As we lately explained, the mosquito net must be a reality, and must be so made and arranged that no insect can bite through its

meshes, or enter through casual openings in its structure. Great praise must be accorded to the Colonial Office for having so readily furnished the necessary means for the crucial experiment on the Campagna; and it cannot be doubted that so remarkable a departure from routine has been mainly due to the personal initiative of Mr. Chamberlain. A thoroughly practical man himself, he was quick to recognise not only the importance, but also the essentially practical character, of the advice which Dr. Manson and his colleagues were able to place before him.

Dr. Manson informs us that since the above article was published one of his laboratory assistants, who took up the feeding of the Roman mosquitoes when Dr. Manson's son fell ill, has developed fever. The parasite has been detected in his blood and he has had a temperature of 103° .

LOVER OF STATISTICS.—A not unfair illustration of the way in which many "statistics" are constructed is afforded by the story of the farm-boy who reported to his master that he had seen a hundred and seven crows in one field. "You young rascal," said his master, "how do you know that? I am sure you cannot count a hundred." "No; but I counted seven, and I am certain there were a hundred more."

* * *

ENQUIRER.—England consumes every year 240 million bushels of wheat, of which only about 30 millions are the produce of her own soil.

* * *

H. S. P.—The following are, we believe, the principal dates as to the appearance of leprosy in South Africa:—Three cases were noted at Drakenstein as early as 1756. These were the first on record in the colony, and were in Dutch. Graaf Reinets had a small leper asylum as early as 1817. Hemel en Aarde was established in 1817, about which time leprosy increased amongst the Hottentots and bastards (slaves and free blacks). More recently another leper establishment has been constituted at Lovedale (Empjanyana). It is near King Williams Town, south of Kaffraria.

* * *

It was suggested to the Commission that the annual mortality among lepers on Robben Island was not less than 20 per cent. (p. 340).

Dr. Impey gave evidence that the average life of a leper on Robben Island was about five years only. Asked if there were not patients who had been there for forty or fifty years, he replied, "Self-cured cases. Yes."

* * *

DR. P.—France has a birth-rate of 22·4 per 1,000, and a death-rate of 22·3, thus its population remains almost stationary. The average duration of life, however, is stated to be 34 years as against 29 in England. This calculation for England, is, however, based on data collected as far back as 1841, none more recent being obtainable.

* * *

In England the registered mortality from inherited syphilis has declined since 1883 from 1,773 to 1,285 in 1897, that is nearly one-third.

COLLEGE NOTES.

BY THE DEAN.

THE Michaelmas Term of Practical Classes was entered upon on Monday the 17th ultimo. The entries are not so numerous as we would wish them to be, but it is to be expected that, as regards class-work, this will be the lean term of the year. It will be a matter of great convenience if, in future, those who contemplate joining one or more of these classes will not leave the announcement of their intention till the last moment, but will communicate with Captain Pinch long enough beforehand to enable him to complete the necessary preliminary arrangements with the lecturers. Some annoyance and considerable disappointment has once or twice arisen from the confusion caused by late applications, and it is the desire of the teachers, no less than of the executive, that so far as is possible the organisation should be such as to prevent either disappointment on the one hand, or overcrowding on the other.

* * *

ARRANGEMENTS have been made with Mr. Johnson Smith, F.R.C.S., for the conduct of a class on Operative Surgery at the Dreadnought Hospital, Greenwich. The fee will be four guineas, and the size of each class will be limited to a maximum of six or a minimum of four members. Each class will be arranged for at a time to suit those composing it, and the syllabus will include all important operations and methods of modern surgical procedure.

A class of this kind has been constantly enquired about, and now that it has been satisfactorily provided for, the Council trust advantage will be liberally taken of the opportunities offered.

Mr. Johnson Smith's reputation as a teacher is too well known to require further recommendation than the mention of his name, and he is so fortunately situated at Greenwich as to have the command of all the facilities necessary for making such a course of instruction complete and thoroughly practical. Greenwich is easily

reached by frequent trains in about half an hour from Charing Cross, Fenchurch Street, Snow Hill, or Victoria, and the hospital is situated close to the railway stations. Captain Pinch will be glad to give full particulars of the proposed class to those desirous of joining, and it will be convenient if application can be made in time for a first course to be completed before Christmas.

* * *

RUMOUR has it that at least two members of the Polyclinic are aspirants for parliamentary honours. The presence of a larger number of medical practitioners in the House of Commons is much to be desired, and those from our number who are reported to be ambitious of adding other two letters of the alphabet to the long string they are already entitled to write after their names are most excellent men, who will do credit to whatever constituency they represent. None will rejoice more over their success than their confrères at Chenies Street.

* * *

AFTER due deliberation, and as the result of representations made to the Council, it has been decided to revert to the original plan of an over-all membership fee of one guinea. It was assumed that the town member, on account of his proximity to the College, would have it in his power to get "greater value for his money" in the matter of more frequent attendance than his provincial neighbour, and that therefore he ought to pay more; but it is doubtful whether in reality he has actually taken anything like such full advantage of his opportunities as it was thought he might do.

The very fact of its convenience tempts him to put off from time to time the course of attendance he has, ever since joining, promised himself, and the daily and hourly demands of an exacting public make it often difficult for him at the last moment, when he comes to try it, to withdraw himself even for a few hours from the exigencies of his daily work. The provincial member, *per contra*, comes to town for the special purpose of attending the meetings and taking part for a longer or shorter time in the work of the College, and consequently takes the trouble to make due provision for temporary absence. Our experience, so far at any rate, goes to prove that for this or other reasons the town members have not overwhelmed us,

and the Council have therefore yielded to the arguments in favour of a membership fee for all of one guinea only. Doubtless there are practitioners to whom this reduction of fee is a matter of consequence. Many men, apart altogether from the question of being able to afford it, hesitate to commit themselves to an annual burden of two guineas, but think little of one, more especially when it stands good for a certain amount of value received. It is this principle more than any other that has conduced to the success of the British Medical Association, and it is not an unreasonable hope for the Council to cherish that the nominal subscription now asked will be the direct means of producing a large addition to our membership. We ought to number as many thousands as we now do hundreds, and would then be in a position which would financially justify consideration being given to extension of our work in many desirable directions and to the issue of a weekly instead of a monthly journal. In many respects a weekly issue of the POLYCLINIC would be an enormous advantage, and it is beyond doubt that a moderate amount of co-operative and energetic push on the part of our present members would rapidly enable such a desirable consummation to become an accomplished fact.

* * *

THE experiment of an autumn vacation has answered well, and though the fear of the temporary closing of the College might be an inconvenience to a certain number of members may have been justified in a few cases, it would seem from such expressions of opinion as have been heard that on the whole it has been an acceptable policy.

Whenever the membership-roll contains a sufficient number of provincial names to make it necessary to provide facilities during August—when so many can best get away from the duties of practice—it will be time enough and easy enough to arrange for keeping the College open and carrying on the consultation work without a break the whole year through.

* * *

OUR members will rejoice to know that Dr. Miller Ord, our late Chairman of Council, is much improved in health. We all trust this good news is the prelude to such permanent restoration of

vigour, that we may see him among us again during the coming winter.

His absence has created a great blank both at the Council table and in the consultation rooms.

* * *

DR. BYROM BRAMWELL, of Edinburgh, delivered his lecture on "The Diagnosis and Treatment of Intracranial Tumour" on September 12 before one of the largest and most appreciative audiences which has filled our lecture-hall since the opening of the College. The address was an instructive and masterly exposition of the wide subject of cerebral tumours, and entered in great detail into the difficult question of differential diagnosis. In the matter of treatment special stress was laid upon two leading conclusions at which Dr. Bramwell has arrived:—(1) that only tumours whose seat of origin was the dura mater offered much chance of satisfactory removal; and (2) that any increase of intracranial pressure militated very strongly against the probable success of operative interference. The lecture will appear in an early issue of the POLYCLINIC.

* * *

THE College opened for the work of another year on Monday, September 3, and the claim which it has already established for popularity has been further asserted by a gratifying increase in the attendance of members.

* * *

A SERIES of three demonstrations on "The Surgical Anatomy of the Nose and its Accessory Cavities, including Nasal Suppuration," will be given on December 3, 10, and 17 by Dr. StClair Thomson (free to all members of the College).

Lecture I. December 3 at 5.15 p.m. Room No. 1.—The external configuration of the nose. The roof. The alæ narium and vestibule. The mucous membrane and blood supply. Nasal respiration. The septum and its relation to spurs, deviations, epistaxis, perforating ulcers, angioma, sarcoma, tubercle, papilloma, epithelioma, and syphilis.

Lecture II. December 10 at 5.15 p.m. Room No. 1.—The outer wall of the nose; inferior, middle, and superior turbinals. Nasal polypi. The maxillary antrum; the frontal sinus: their

situation walls, relations, and methods of opening. Pus in the inferior meatus of the nose. Pus in the middle meatus of the nose.

Lecture III. December 17 at 5.15 p.m. Room No. 1.—The post-nasal space. The choanæ. The sphenoidal sinus. The posterior ethmoidal cells. The posterior inferior turbinals. Naso-pharyngeal adenoids. Post-nasal catarrh. Post-nasal suppuration.

* * *

A MEETING of the Standing Committee on *Tuberculosis* will take place on Thursday, October 25. Dr. Heron is the chairman of this committee. The subject will be the external affections supposed to be in connection with Tuberculosis (see report of a former meeting at p. 190). The meeting will be open to all members of the College.

DEFINITIONS OF WORDS AND TERMS.

WE purpose in future to devote occasionally a column of the POLYCLINIC to the definition and explanation of Words and Terms. Attention will of course, be chiefly given to those which are of recent introduction, and concerning which knowledge is not as yet a matter of common possession. It may, however, be desirable occasionally to notice some which have long been in use, but which it is desirable to employ with greater explicitness and more clear comprehension of the meanings which they ought to carry. In the task which we have undertaken, we hope to secure the co-operation of our readers. The mention of new words requiring explanation—with or without suggestions as to what their definition should be—will be gratefully received by the Editor.

The Lexicon published by the New Sydenham Society is now complete, and it may be well that those purposing to assist us should take it as a base. All words not mentioned in it may be considered new, and respecting many which are there given it may well be the case that the definitions will bear amplification, and in some instances even require correction. The Society purposes soon to publish an Appendix and the information which we now seek to accumulate may be useful to its future editors.

We believe that this column will tend to subserve the great objects of the Polyclinic College and its Journal, which are to diffuse

knowledge in all ranks of our profession and to increase interest in its pursuit. Nothing more hinders progress than inexactitude in the use of words and ignorance of their real meaning. In conformity with these aims nothing that appears in this column will be considered as concluded or stereotyped. On the contrary, we shall gladly, if found desirable, recur again and again to the same word until an adequate exposition of it is reached.

Lysigenous.—This term is applied, chiefly by botanists, to cavities which are formed in otherwise solid structures by the breaking down and destruction of cell material. It is thus in contrast with

Schizogenous.—A term applicable to cavities formed by the pushing aside of uninjured cell structures. A splitting of the common wall of adjacent cells.

Saprophytes.—Saprophytes are plants which live on the decomposing remains of other organisms, whether animal or vegetable, *e.g.*, *Monotropa*, *Neottia*, mushrooms and many fungi. If an organism avails itself of the juices of a living structure it is said to be parasitic; if of dead and decomposing material it is a saprophyte. The latter term is, however, applicable only to plant life. We have no equivalent term for animals which make use as food of substances undergoing decomposition.

Chlorotic.—This term, signifying green, has received a curious subversion of etymological meaning in the case of plants. Most plants in a healthy state are green = chlorotic; but a chlorotic plant or leaf, in the conventional or botanists' sense, is white. It is one in which the chlorophyl process has failed. Thus the word comes to mean simply defect of natural colour. A chlorotic girl has lost her rosiness and become pale, with possibly a tinge of green. A chlorotic plant has lost its green and become bleached.

Sprue.—A name given in the East to a chronic and sometimes fatal form of muco-enteritis. It is often attended by a sore mouth and a peculiarly red tongue. Its causes are not known. The name is a native designation, possibly for thrush.

Psilosis.—This word signifies simply a stripping bare or making bald. It ought not to be used as equivalent to "Sprue," although the latter is attended by a red bald tongue and general atrophy of the intestinal mucous membrane.

Biopsy.—This word is used in modern French works, notably in Dr. Pringle's translation of the "St. Louis Atlas of Skin Diseases." Having applied to a distinguished French scholar to know what it meant, we received the following: "A 'Biopsy' is an autopsy on a living subject—which is Irish!"

We must object, however, that the term "autopsy" has only by conventional usage come to mean a *post-mortem* inspection. Etymologically the word means simply "a self-inspection," or an inspection under one's own eyes. The word Biopsy is therefore not really a bull, although suggestive of one. It might be better written Bioscopy. It may be applied to all visual examination of organs or tissues during the lifetime of the patient, but will probably be conveniently restricted to those in order for which a cutting operation is required.

CORRESPONDENCE AND ANSWERS.

NEMO, whilst expressing the warmest approval of our suggestion that the practice of circumcision of infants should become universal (see Leader, page 129), avows his belief that a "twentieth century Moses" will be needed to make it so. Nothing short of a religious sanction will, he thinks, avail to make it accepted. We do not by any means share his unhopefulness. His proposal that the medical profession should set the example is a good one. If medical men were able to say to their patients "we always perform the operation on our own children," the statement would have great weight. With many parents it would not be necessary to go into detail, but would be sufficient to say, "We consider the practice conducive to moral and physical health, and strongly recommend it."

* * *

' DETECTION OF A DIAMOND IN THE LARYNX BY MEANS OF THE X-RAYS.—A man accused of having stolen a diamond worth 10,000 rupees from a Calcutta jeweller's shop, was sentenced to two years' imprisonment. The *Daily Mail's* Simla correspondent says that, "a photograph of his throat, taken by means of the Röntgen rays, showed that the man had adopted the plan common among Indian thieves of first swallowing the jewel and then adroitly guiding it into the sac of the throat, whence he could reproduce it whenever he liked. All efforts to extract the jewel from his throat failed. This, however, did not interfere with the verdict."

* * *

DR. P. WRITES US: "What exactly is psilosis, or 'sprue?' What is its usual *duration*, and what its prospects of recovery? None of my medical books contain a word about it, and I don't know at the moment where to lay my hands on any definite and trustworthy information. I shall be greatly obliged by as brief a reply as you please." We have referred Dr. P. to Manson's "Tropical Medicine."

* * *

MOSQUITOES AND NEGROES (*To the Editor of THE POLYCLINIC*).—SIR,—On page 65 of the *POLYCLINIC* (vol. iii., No. 7, 1900) you ask "Do mosquitoes attack the negroes?" They do. If you go among the Dinkas and Neuhrs, who live near and on the White Nile Marshes (Bahr-el-Gebel), you find that they protect themselves from the attacks of the mosquitoes by covering themselves with ashes and by the smoke of their fires.

With regard to the other points raised in your paragraph, it may be of interest to know that a residence of a year in England renders negroes as liable to malaria as Europeans; also that negroes from the States suffer severely. I found that if one took porters in Central Africa for more than three or four days march from their homes that they suffered from fever, and that has always seemed to me to point to a local immunity.

I am far from thinking that mosquitoes are the *sole* cause of malaria. Why do all Arabs sleep with their heads covered so as not to breathe the "bad air?" It is not so much the mosquitoes they mind as the damp, fœtid exhalations from the marshes. It is a wide question, however—too wide for a single note.—R. W. FELKIN, M.D.

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. III., No. 11.—NOVEMBER, 1900.

IMPERIAL MEDICINE.

IF we venture to associate medical science with Imperialism it is in no grandiloquent sense. The perception of Imperial responsibilities which has developed so rapidly of late is one in which our profession must take its share. The more promptly and fully this is done the greater will be the advantage both to medical science and to mankind. Our meaning is that the scope of medical research has widened, and must in the future include many branches of knowledge which in the past have been much neglected. Just as the British statesman of to-day must make himself acquainted with geography and its cognate sciences in detail which his forefathers did not dream of, so it is with ourselves. We must no longer be content to be familiar with British maladies and British therapeutics, not even with the triumphant additions of modern surgery; but must learn to look on our vocation in a wider and more liberal aspect. The needs of the age have thrown the responsibility upon us, and our duty is obvious. It will not suffice to send out to our colonies and distant dependencies men well trained in European knowledge, and leave it to them to acquire, as best they may, local experience on the spot. Something better than this is required of us. No pains should be spared to collect fragments of observation from all possible sources, and these should be carefully scrutinised,

arranged, and made available to all. The emigrant medical man should go out to his distant location well informed as to what he will have to deal with and what he ought to observe. Nor does this demand for wide knowledge restrict itself to the study of disease only. We take as our scope of labour and of responsibility the general health of the community, and in connection with that the study of climate, of race, of social habits, and of food are of the utmost importance. The prescription of drugs and the performance of operations are no longer the only vocations of the practitioner.

The two Schools of Tropical Medicine which have recently been founded in England are important recognitions of the need of Imperial medicine. It is to the honour of Mr. Chamberlain and the Colonial Office that to one of these, at least, Government aid has been granted, and never probably was public money invested to greater advantage. Whilst, however, the tropics embrace, it is true, a large proportion of the recent accessions to the British Empire, they are far from including the whole. South Africa, Australia, New Zealand, Canada, and innumerable smaller dependencies, far north or south of the tropics, have also their claims. Tropical medicine is by no means co-extensive with Imperial medicine, and the loss will be great if we permit any arbitrary restrictions of latitude to limit the comprehensiveness and destroy the unity of scope which should characterise our work. Although it is true there are diseases which appear to be endemic and local, the primary elements of morbid causation are for the most part world wide, and even where they differ most, the facts obtained in one locality often illustrate instructively those of another.

As has been hinted above, the study of race, climate, and food are fundamental to Imperial medicine. These topics have in the past been left far too much to chance observation. Travellers have recorded only the facts which impressed themselves, and the information which they give us is supplied only in a fragmentary manner. What is needed is careful and systematic investigation by skilled persons. No surgeon travelling abroad should neglect his opportunities for adding to our general knowledge of medical geography. Nor is this kind of information destitute of interest for the British practitioner. Apart from the useful sidelight which it is certain to throw upon his daily avocations, it will supply him with answers to

many questions to which he is even now occasionally liable, and which are sure to be put to him with increasing frequency in the future. Not only will the migration of invalids to more propitious regions become every year more feasible, and advice respecting it more sought for, but the movement of the non-invalid population over the surface of the globe is now so free that the opinion of the practitioner as to the salubrity of this or that region must necessarily be in frequent request.

If we turn to special diseases which are of Imperial interest, Gout—the *morbus dominorum, dominus morborum*—and its allied affections, rheumatism and calculus, ought perhaps to be taken first.

The relations of these maladies to climate on the one hand and to diet on the other are of the utmost interest. The questions which they involve can be answered only by the patient collection of evidence. The theories of chemical pathologists however ingenious, the speculations of neurologists however bold, will never suffice to take the place of cautious inductions from carefully-noted facts. Who shall tell us why calculus is common in Norfolk and unknown in the north of Ireland, or why it is so prevalent amongst the vegetarian Hindoos? Amongst the urgent desiderata for our home population is the knowledge of a climate which is beneficial as a place of permanent residence in chronic rheumatism. We shall know much more about gout than we now do when we have trustworthy information as to the regions and races which are wholly free from it.

The cognate, and possibly substitutive, maladies, Tuberculosis and Leprosy, demand also for their full comprehension almost world-wide knowledge. They are both probably world-wide, although not universal, in their prevalence, and exact information as to habits in reference to food, clothing, and social customs of those communities which are immune and those which suffer heavily, would help us far in the way of our search for their predisposing causes and the means of their prevention.

More accurate knowledge as to the modifications of the phenomena which attend Syphilis in different races and under different skies is exceedingly desirable. The natives of Fiji are said to have been from time immemorial liable to a peculiar bone disease, to have

also suffered from what is called yaws, but to be to this day free from syphilis. Who will procure for us some of the bones so affected, and let us see in what features they differ from those which are damaged by syphilis? Facts have been adduced in our pages which seem to tend strongly in the direction of belief that the Yaws of the African coast and the West Indian Islands and the Parangi of Ceylon and the East Indies are neither more or less than syphilis as modified by race and climate. There are, however, men of much special experience who yet deny this conclusion. More facts, and above all more exact and more detailed facts, are required. It is needless to state that in the solution of this problem, as also in those as to Leprosy and Tuberculosis, the interests of millions of sufferers are concerned.

Amongst the many more limited and more local topics which need home study may be mentioned the Verrugas of Peru and the Sprue of the East. Verrugas is a malady which, so far as is yet known, occurs only in certain mountain valleys in Peru. It is a febrile disease attended by a peculiar fungating eruption, which persists for long, and often proves fatal. Our Polyclinic Museum is fortunate in possessing the first portrait of this malady ever taken in Europe, and possibly the only one. The life of a young and enthusiastic physician has recently been sacrificed to an experiment which appeared to prove the essential connection between the fever and the eruption and also the contagiousness of the disease. No satisfactory theory is, however, as yet obtainable as to the real nature of the disease and its causes. The discovery of them and the explanation of the restricted prevalence of a disease so peculiar and presumably so contagious would probably open a new chapter in pathology.

Sprue is the name, meaningless and in every way unattractive, by which we are asked to recognise a chronic and often fatal form of gastro-enteritis which occurs in China and the East. It is attended by a sore mouth and a bald red tongue and by remarkable wasting of the intestinal mucous membrane. It is not, in the regions where it is most prevalent, identified with any special cause. The measures of treatment adopted—a milk diet and rest in bed—suggest that it is probably non-specific, and that it has much to do with food. Now, for the British physician there arises the important question

as to whether "sprue" is wholly unknown at home, and what its relations may be with other forms of muco-enteritis. The descriptions given us of the relapsing sore mouth also suggest inquiries as to whether some of the forms of herpes of the mouth or certain obscure pemphigoid affections may not have some relation to it.

We must be content with the illustrations which we have given as to the scope of Imperial medicine. It remains only to add a few words as to the relations of our Polyclinic organisation to its pursuit. We have, in the first place, formed a Clinical Museum into which it is purposed to collect everything that photography and pictorial illustration can afford us towards the full realisation of facts. In such diseases as yaws, leprosy, tuberculosis, syphilis, and verrugas our collection is already rich, and may in many ways afford to the investigator better material than he could obtain elsewhere, not excepting perhaps even the localities where these maladies are indigenous. The College library has also organised special departments for the classification of books, pamphlets, &c., bearing upon these topics. We have appointed several standing committees, which meet from time to time to receive and investigate evidence. At our consultations, also, the production of living patients illustrating, amongst other maladies, those now under consideration, is encouraged. At these consultations we may boast that a case of leprosy has, during the last year, been produced about once a month. Medical men who have resided abroad are at all times invited to favour us with statements of their experience, whether in writing or otherwise. Lastly, we are now seeking to appoint Associated Correspondents in foreign parts. In these and other ways the Polyclinic College hopes to perform its humble share of work in the advancement of Imperial medicine.

THE FIJIS.

THE Fiji Islands, taken together, have an area about equal to that of Wales. They are situated, as all know, between north of New Zealand and north-east of Australia. The group numbers 120, but only eighty are inhabited. Anciently of volcanic origin, they

present no traces of recent disturbance, and deep tracts of sedimentary deposit bear testimony to the lapse of ages since their mountains were formed. Their scenery is most beautiful, its special characteristic being the luxuriant growth of wood, shrubs, and plants, up to the very summits of the mountains. The soil is wonderfully fertile, and perhaps nowhere in the world does vegetative activity proceed more rapidly. Of this fact it is possible that some use should be made in interpreting the peculiarities of prevalent disease. We are assured that a bean put into the ground will display its cotyledon-leaves in twenty-four hours, and that radishes are grown in perfection in four weeks. The climate is delightful, though, in the lower districts especially, somewhat enervating. Many of the mountain peaks rise to a height of 4000 feet, and houses and villages are built on their very summits. It is said that rheumatism is common, but, as we shall see immediately, there may be some confusion with the periostitis of specific disease.

The inhabitants of the Fijis, although of mixed descent, inheriting from the Polynesians and the Papuans, are now a well agglomerated race, and speak the same language with only dialective differences. They are physically a fine race, and in many respects their civilisation much excels that of the neighbouring groups of islands. A high estimate of the value and attractiveness of human flesh as food attached to them a special stigma up to the date of their conversion to Christianity. They were, however, in other respects far in advance of most cannibal savages.

The Fijis are of especial medical interest on two accounts ; first, because there is prehistoric evidence of the existence of leprosy in them, and next, because they are a native home of the disease now known as Yaws or Framboesia. This latter malady is met with on all the islands, and is almost universal. It is said that mothers inoculate their children, desiring to get it over in early life. Although, however, for the most part, a disease of early life, it is met with also in adults. Its characters we need not stop to describe ; they are the same as those of framboesia in other parts of the world, and are well illustrated by the portraits which we have given. It is said that the disease keeps well to its type, and that one case is like another.

The Fijians are reported to be thus far free from syphilis, unless indeed yaws be syphilis. In former times their cannibal propen-

sities may easily be allowed to explain the non-introduction of syphilis by English sailors, but since they became Christians there has probably been sufficient opportunity in that direction. Although they are not a sexually immoral people in any strong sense, enough has occurred to induce the suggestion by some medical men that yaws does in some way give them immunity as regards syphilis.

From time immemorial the natives of Fiji have been liable to peculiar and painful forms of bone disease. They had a native name for this before Europeans landed there. Dr. Daniells, who has resided in the Fiji, as Government surgeon, also tells us that in addition to this bone disease they are liable to severe forms of ulcerative destruction of the palate and adjacent parts, and that they suffer much from lupoid affections of the skin.¹

The Fijians drink an intoxicating liquor called kara, in the making of which the root of *macropiper methysticum* is an essential.

Fijians build good and elegant houses, make excellent pottery, and excel as cooks. They are musical and have their own poetry. It is said that their warfare was always conducted "with many courteous formalities." In common with their neighbours, the New Zealanders, they had no domestic animals before the advent of Europeans. Fish, molluscs, and crustaceans constituted very important elements in their food supply. The yam is the staple article of vegetable food, but a great variety of fruits and roots is available.

Dysentery, now common, is said to have been unknown before the ingress of Europeans. Influenza (contagious catarrh) is at times prevalent, and rheumatism is said to be common. It is very possible, however, that the peculiar form of bone disease which follows yaws may often rank as "rheumatism." Fevers are said to be hardly known.

Of late years there has been a considerable immigration of Indian labour, under indentures, into Fiji, and the Government is now adopting measures designed to induce these labourers to remain as independent settlers. Their chief employment is the cultivation of the sugar cane. The population at the end of 1899 was estimated at 122,673, of which 98,478 were natives, 13,282 Indians, and 4,373

¹ Mr. Coutts Trotter, the non-medical writer of the article on Fiji in the "Encyclopædia Britannica," thus speaks of these affections :—"The natives have a bad skin disease, thoko, affecting also the bones, from which few escape."

Europeans. The native population is diminishing, for although the birth-rate is high, the death-rate is still higher, chiefly in connection with excessive infant mortality. It is hoped by attention to house accommodation, and especially to better water supply and better training of the women, that the rate of mortality may be reduced, and already there are signs of improvement. As a whole, Fiji is prosperous; its assets exceed its liabilities and its income its expenditure. Its imports in 1899 amounted to £261,044 and its exports to £481,856.

HAIRY MEN.

THERE is a strange old proverb which declares "there is no wife for a hairy man." Whether it has any bearing as relating to sexual preference in explanation of the disappearance of hair from the human skin may be open to question. It would be quite contrary to fact to suppose that absence of hair is always an indication of development in humanity. Some races by no means high in attainments have remarkably smooth skins, and probably amongst our own population the most remarkable examples of a hair-growing skin would be found in Jews, a race second to none in intellectual achievements. The Ainos, the aboriginal population of Japan, are probably the most hirsute race on the face of the globe. Mr. R. G. Watson, in an article in the *Journal of the Royal Geographical Society*, says of them: "They are well-grown men with good features and an immense quantity of coarse black hair covering nearly all parts of the person." He tells us also that the Japanese, who are now their masters, are anxious to improve their condition and at the same time their character. With that keen perception of the practical and that absence of sentiment which characterises Japanese methods, they purpose to send to the hairy Ainos some of their own daughters as wives. Mr. Watson writes: "There is in the Yezo colonisation department a school at which fifty Japanese girls (daughters of officials) are being educated at the public expense by Dutch instructresses. These girls are, I was told at the school, destined to be the wives of Ainos."

MEMORANDA AS TO THE AINOS.

The Ainos race is of much interest as one which has probably from very ancient times maintained an insular separation from all others. It is now disappearing under the influence of its subjugators, the Japanese. Remnants of it are still found on several of the islands of Japan, but the largest number are on that of Yezo. Mr. Watson, from whom we have quoted above, supplies us with the following notes. They are great fishermen, and are accustomed to export fish (sardines) which have been dried in the sun to be used as manure. "An Aino village is almost invariably built on the sea shore." Their huts are piled round with fuel, dried fish, and cooking utensils. "An Aino's food is fish, roots, and venison. There is in each hut a loom, and on the whole the interior presents more appearance of comfort than one would expect from the rough appearance of the Ainos themselves. They are a remarkably strong race and are individually very courageous, though collectively in abject terror of the Japanese."

There has as yet been little or no admixture with Japanese blood. The married women do not adopt the Japanese married women's custom of staining the teeth black.

The Kurile Islands are inhabited by Ainos, and the latter are sometimes designated as "Hairy Kuriles."

"They worship the sun and a Japanese power which merely means force; they likewise adore their ancestors."

In the rivers and on the coasts of Yezo salmon and other fish are in enormous abundance. Salmon is so cheap that it scarcely has a price.

RACIAL TENDENCY TO FATTEN.

A TENDENCY to put on fat is observed in very different degrees in different races. Habits of diet and conditions of food supply are, no doubt, the main influences which determine it. The Zulu, living on maize, and millet, and milk, and drinking freely the thick Caffre beer, fattens as easily as a pig and almost to a like extent, whilst the Australian, who keeps no flocks and cultivates no grain, is always lean. That there may however be, and probably is, a racial peculiarity in this respect, which is to some extent independent of the diet

of the individual, we may freely admit. Goats remain lean under conditions which fatten sheep. A fat goat, in the sense in which we should speak of a fat sheep or pig, is never seen, yet sheep and goats are so nearly allied that they will breed together. Is it an ethnological fact that the woolly-haired races tend to fatten more easily than the lank-haired? Many exceptions might doubtless be found to it, for the Japanese, Chinese, and Jews, all fatten easily, and all have straight hair. Possibly, however, there is no exception to the statement that all woolly-haired races fatten. To recur again to diet; it may probably be said that all cultivators of the soil, and, as a consequence, vegetable feeders, tend to fatten, and that all who depend much upon the chase, or upon fishing, remain lean. There is probably a natural or physiological tendency to fatten in the female sex, and amongst civilised nations this often finds its expression. Amongst some of less advanced races, in which women are engaged in all laborious occupations and men are comparatively idle, this sex tendency is more than counterbalanced. It is the Zulu man who gets fat, and it is he who drinks the beer and lolls about the kraal. It would be of interest to collect facts on this subject, and to examine as to whether any connection can be traced between the tendency to fatten and liability to any special forms of disease.

THE CHINESE AND THE MONGOLS.

IN the international study of disease it will be of much interest to compare, when facts are obtained, the Mongols with the Chinese. The Chinese have of late years gradually intruded into Mongolia proper, and have long passed the boundary of the great wall. Wherever they go they take agricultural and industrial arts. The Mongols hold themselves aloof, and regard with contempt the laborious Chinese. They still breed their horses, cattle, and sheep at a distance and pitch their camps on uncultivated land. They drink milk and make butter, which the Chinese never do. There is no intermarriage, no modification of manners, customs, or language. Presumably the Mongols have no fish in any form, and their use of grain as food is comparatively little. It would be of much interest to know the facts as to the prevalence of such affections as leprosy and tuberculosis in two races which live in the same districts, but, as regards food, have such different habits.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

ABSTRACT OF LECTURE ON THE DIAGNOSIS OF EPILEPSY.

BY SIR W. R. GOWERS.

Polyclinic, October 10, 1900.

THE distinction of the paroxysmal diseases of the nervous system, such as epilepsy, has to be learned by description, because the attacks cannot be produced at will for the information of the student. The knowledge thus obtained has generally also to be applied to description, for opportunities seldom occur for actual observation of the attacks in the patients to be treated. These facts render the subject one of considerable practical difficulty.

It is indeed easy to recognise a severe epileptic fit, but the combination of epileptic convulsion with other forms, and the extremely various forms of minor attack, give rise to practical problems which often puzzle and sometimes baffle the practitioner. A frequent source of difficulty is the combination of epileptic and hysteroid convulsions. A patient may be seized with severe tonic epileptic spasm, with loss of consciousness, and pass directly from this into a condition of violent co-ordinated movements, struggling and kicking, sometimes for a few minutes, sometimes for a longer time. The nature of such attacks is often hard to discern from description, but it must be remembered that the convulsion in which patients bite the tongue is always epileptic, and that in which they have to be held down is hysteroid, that the epileptic fit only lasts for a few minutes, while the hysteroid convulsion may continue for a quarter of an hour or longer. It must be remembered also that fits which go on at intervals for years are always essentially epileptic. Another source of difficulty in this connection arises from the fact that hysteroid convulsion is the more pronounced, and the longer in duration the slighter the epileptic fit. Often the epileptic stage is manifested only by a fall and a moment's

rigidity, and is apt to be overlooked, and such cases to be mistaken for pure hysterical attacks; an error which is facilitated by the fact that the most severe forms occur in those who are predisposed to hysteria, and the subjects may have at other times pure hysterical attacks.

The recognition of the minor attacks is often difficult, because their nature is not suspected and no notice is taken of them. A patient may think that epilepsy has existed only for a short time since his first severe attack; when, on inquiry, it is found that slight seizures had occurred for years before. The patient may be unaware of them because loss of consciousness is absolute and sudden alike in its onset and cessation. Then they can only be ascertained from the friends. Or the loss of consciousness may be partial, and the attack may be only manifested by some sudden sensation of which the patient alone is conscious, since there may be nothing to attract the attention of others. To ascertain them it is well to ask if the patient has experienced any sudden momentary sensation, coming on without cause and immediately passing off. Sometimes, however, it is necessary to put "leading questions," which are not practically found to involve the risk of error they entail in many instances. The patient should be asked for momentary giddiness, especially when still, a momentary feeling of strangeness, stars or light before the eyes, or momentary darkness, or a dreamy feeling, or any sudden sensation at the epigastrium or elsewhere. As a matter of experience, these sensations are not admitted unless they have been felt, apparently because the subjects of them are only too anxious not to be found guilty of anything for which the doctor is searching. Giddiness is one of the most important of these sensations, especially significant if it occurs when the patient is still. But epileptic vertigo is occasionally excited by a sudden movement, its nature being otherwise clearly shown by obscuration of consciousness and occurrence only before a severe attack. In this relation it resembles the excitation of other minor attacks by a startling event, as a sudden noise—an effect which is intelligible when it is considered that a "start" depends on widespread excitation of the motor cortex. Giddiness, however, furnishes another difficult diagnostic problem, because that which is of the nature of aural vertigo may occasionally closely resemble the giddi-

ness of epilepsy. On the one hand, a true epileptic fit is occasionally preceded by a sudden noise in the ear accompanied by giddiness, but the nature of such seizures is generally manifest, and the patient has not prominent symptoms of aural disease, such as are presented by the subjects of labyrinthine vertigo. On the other hand, in the latter the intensity of the giddiness is often extreme. All giddiness involves an imperfection of one element of consciousness, the relation of the individual to his environment. The onset of the attack of true aural vertigo may be so sudden that the patient feels as if he had received a blow on the head which knocks him down, and it is not surprising that there should be actual loss of consciousness in some of these cases, brief but distinct. As a rule they are characterised by the persistence of vertigo as the patient recovers, often attended by vomiting and always by prominent symptoms of labyrinthine disease; it may be slight, but definite. As a general rule, moreover, aural vertigo is objective and subjective, but epileptic vertigo is generally, although not invariably, subjective only. But cases are met with in which such sudden intense attacks of vertigo, which must involve the cerebral centres in their disturbance, seem to facilitate the occurrence of loss of consciousness, so that it occurs readily and frequently, and some of the attacks may closely resemble those of epilepsy. An error is easy unless care is taken to discern the differential features of the two diseases, and the practitioner also knows their tendency to resemblance. In all cases of the diagnosis of these paroxysmal diseases some knowledge is essential, but far more important is the manner in which it is used, the care which is taken to scrutinise the features of the attacks, and to give their associations due weight. Knowledge can never be dispensed with, but in all processes of diagnosis that which is of most importance is care in the comparison of symptoms and an effort to discern the evidence, direct or indirect, of their cause, before the application of any routine diagnostic data.

SELECTIONS FROM CLINICAL LECTURES.

BY JONATHAN HUTCHINSON, F.R.S.

On a Case of Leprosy in the Macular Stage.

By the courtesy of Mr. Hichens I had, on May 17, an opportunity for demonstrating a very interesting example of macular leprosy. The patient was a lad of 16, of mixed parentage, born in Demarara, and the brother of a younger patient with the same malady whom we had seen on a former occasion. The two brothers were much in the same condition, but in the younger one the disease was of the longer duration and the eruption the more abundant. In both the eruption consisted of large irregular erythematous patches with spreading edges and pale centres. They might have been taken for dry eczema. In our present case I draw attention to the following points:—

That the eruption was abundant in a long streak on the left upper extremity, whilst there were only very insignificant spots on the right limb. This failure of bilateral symmetry was further remarkably illustrated by the condition of the ulnar nerves; on the left the nerve was very much enlarged, and could be traced from the internal condyle to the armpit as a hard cord as thick as a cedar pencil; whilst on the other side it could only be found with difficulty even behind the condyle. This affection of the nerve was attended by corresponding failure of sensation and of muscular power in the hand, though neither were complete. The first symptom of the disease had been a patch on this arm. I took occasion to observe in almost all cases a patch of brown skin was the first symptom of the disease, and that there was never anything of the nature of a primary sore nor any reason to suggest local infection. From the patch of skin first affected the morbid process travelled up the sensory twigs until, meeting with the motor ones, the mixed trunk became involved. Thenceforwards we had to deal with a peripheral neuritis and its consequences, but it was, I remarked, very important to remember that there were two forms of anæsthesia. One of these was primary to the skin, depending upon destruction of the nerve papillæ; the other secondary, consequent upon neuritis of the nerve trunk. The latter was always distributed

according to the known distribution of the affected nerves; the former was quite irregular in relation with the patches of erythema.



The hand of a leper showing the results of neuritic destruction of the ulnar nerve. In addition to anæsthesia of the nerve-territory there is atrophy of the muscles of the little finger, and of those between index and thumb. The little finger is contracted, and the ring finger slightly so.—From Dr. Ehlers.

The muscles, I said, were always affected secondarily from the neuritis, and never primarily. As a rule, the lesions of leprosy are

located with fairly accurate bilateral symmetry, a circumstance of some importance as implying that they are due to a blood cause. They are never in any approach to herpetiform arrangement. In the present patient, although as regards the upper extremities the eruption was almost solely on one side only, yet on other parts—the buttocks and thighs—the patches, very few in number, were placed with exact symmetry. Next I drew attention to the absence of some of the symptoms usually reputed as diagnostic of leprosy, such as changes in the face, ears, and nose, and falling of the eyebrows; and remarked that no one would have suspected the boy of being a leper until he was stripped, and that even then the diagnosis would be missed, excepting by a skilled observer.

As regards treatment and prognosis, I advised the use of a very liberal diet, with wine and plenty of flesh meat, and, as a medicine, small doses of arsenic and quinine. Entire abstinence from all forms of fish should be insisted on. There was good reason to hope that the malady might be arrested, for it was becoming increasingly probable that not a few leprosy patients who made a complete change of dietetic habits got well.

On the two forms of Purpura.

I draw a strong distinction between purpura with extravasation and purpura with thrombosis. Commonly, I believe, they both rank as purpura, and in some—perhaps in many—cases they complicate each other. Yet the two conditions are distinct, and they often depend upon a quite different set of causes and ought to suggest a quite different prognosis.

A little girl who was brought to our consultation theatre a few weeks ago may stand as a good illustration of the extravasation form. You would have thought that the poor child had been beaten black and blue. On her legs and arms were large bruise-like patches. We were told that there had been smaller ones of brighter colour, but these had quickly vanished, or had become lost in the bruises. We were also told that there had been epistaxis. The child was bright-eyed and intelligent-looking, but very pale. She had not been thought to be specially ill, and there was no history of rheumatism.

I have purposely avoided the use of the term hæmorrhagic, for

the disease known conventionally as "purpura hæmorrhagica" constitutes a clinical form of disease by itself, and flux and repeated bleedings from the mucous surfaces are almost essential to it. In the child's case which I have mentioned no doubt this name might suitably be employed. It is a rather mild form of a grave and often fatal disease. What I want, however, to insist upon for the present is that the two lesion thrombosis and extravasation are distinct, and later on, when that point is established, we will discuss the clinical relationships of the two, and the cases in which they occur together. Before proceeding further, let me just illustrate the hæmorrhagic form by briefly mentioning two other cases which, as they occurred when I was young, made a deep impression upon my memory. When I was house-surgeon to the York County Hospital there was a young man in one of the wards with disease of the hip-joint. He had been in the hospital a month or more, and was having the ordinary liberal diet when suddenly purpura spots and bruises began to appear on his limbs and he had bleeding from his nose and gums. In the course of about a fortnight—I speak from memory—he became hemiplegic and next comatose, and so died. We found a large soft clot in one hemisphere of his brain and numerous other patches of extravasation in his pia mater and on most of his serous membranes. As to the influences which had brought about this sudden inability on the part of his blood-vessels to retain their contents there was no evidence whatever. About the same time I saw several other fatal cases of hæmorrhagic purpura, and in none of them was there any obvious cause as regards diet or other influences on health. One of them was in an infant which had been wholly fed on milk. Thus we get a clear impression that there is a condition which may be manifested suddenly in apparently healthy persons who have undergone no privations, of which escape of blood from the capillaries in various positions, the skin amongst the rest, is the most prominent feature. We shall probably not be far wrong if we believe that the subjects of this malady are almost always young persons. We may know the malady conveniently as "purpura hæmorrhagica," but let me again insist that not all examples of hæmorrhagic purpura amount to "purpura hæmorrhagica," and that many are probably in no sort of alliance with it.

Leaving, then, a whole host of cases which stand between them, let me now offer for contrast a typical example of thrombotic purpura. This is an affection not often seen, I think, until adult age, and more frequently after the middle period of life.

The case which I will select for our purpose is that of a clergyman, aged 77. He is tall and wiry, an energetic man accustomed, in the active discharge of his duty, to stand a great deal. He had never before been the subject of any skin disease when he came to me one morning with his right leg spotted over with little red lichenoid papules. They had been present only four days, and as yet were confined to one leg. They were very irritable.

On an Obscure Injury at the Elbow-joint.

Gentlemen, the man before us, a muscular cellarman, received an injury to his right elbow eight days ago. He was trying to stop a heavy barrel which was coming down a steep incline, and which did actually strike his face before he succeeded with uplifted hands in stopping it. He did not know at the moment that he was hurt, but immediately afterwards he found that he could not use his right arm well. He nevertheless continued to attend to his work for several days. He has shown that he can flex, extend, supinate, and pronate, all fairly well and without pain, but there is a limit both to extension and flexion; at a certain point, when nearly complete, both these movements are arrested as if by a chock. He carries his arm slightly flexed, and says that if he tries to extend it fully his thumb and some of his fingers tingle and feel numb. His little finger is not involved in this, and his location of these sensations suggests the median nerve-trunk. I have, as you have seen, with both arms fully stripped, carefully compared the two elbows. There is no evidence of contusion and no obvious swelling. All the bony points seem normal. There is, however, some swelling just in front of the inner condyle, and in taking that part between my finger and thumb the man flinched a little, and exclaimed, "That's the spot." I feel no doubt as to there being a swelling here, but it is only slight. Behind the condyle I can feel nothing unusual, and his ulnar nerve-trunk is free and quite painless. On several occasions in rotating the forearm I have thought that I felt a slight click, or grating feel, but it was nothing which I dare call crepitus.

Now for diagnosis. I think that there must be a fracture. The symptoms, although slight, are definite, and are inconsistent with a mere sprain. A muscular laceration might account for disability, but would not explain the limitation of flexion and extension. The most probable hypothesis is, I think, that of a fracture without material displacement of the articular end of the humerus near to the external condyle. We must appeal to the X-rays.

As to treatment I am clear. There is nothing needing reduction nor anything for which a retentive apparatus is needed. The injured parts are in place, or so nearly so that their position cannot be improved. We will therefore not encumber him with splints. A warm fomentation and a sling are all that we shall advise.

LECTURES ON RESUSCITATION FROM DROWNING, &c.

BY DR. BOWLES.

(Continued from page 233.)

LECTURE II.

IN my last lecture I demonstrated to you the nature of the experiments on which the Marshall Hall and Silvester methods for the resuscitation of the apparently drowned were based, and I told you that the Committee of the Royal Medical and Chirurgical Society had confirmed in every detail the results of our experiments, but the Committee, in addition, demonstrated that in drowned animals not only were the air passages choked with fluid more or less bloody, but that both lungs were highly gorged with blood, so that they were heavy, dark coloured, and pitted on pressure, and on being cut exuded an abundance of blood-tinged fluid with many air bubbles in it.

The Committee up to this point made a distinct advance; it settled an important principle of pathology in a clear and definite manner. Before this time, although Sir John Simon and other pathologists had asserted the *presence of water in the lungs* in cases of drowning, the opinion of Sir Benjamin Brodie prevailed both in the profession and at the Royal Humane Society, to which the

public always turns for advice in this matter. Sir Benjamin says in his work on "Pathology," p. 88, "That the admission of water into the lungs is prevented by a spasm of the muscles of the glottis cannot, however, be doubted, since we are unable to account for the exclusion of it in any other manner; and a multitude of circumstances prove that these muscles form a sphincter to the windpipe as perfect in its functions as any sphincter in the body." The Committee showed by their experiments, on the contrary, that Sir Benjamin Brodie's theory of the non-existence of water in the lungs was incorrect; for they *proved* that water *did* exist, at least in animals.

Now instead of showing how this water, of which they admit the lungs to be full, could be first removed and then replaced, *pari passu*, by the introduction of pure air, the Committee advised the adoption of a method which would introduce the largest amount of air into *empty* lungs. I would ask how it was to be introduced into lungs shown to be already full of water? The only effect of forcibly driving in air, which the Silvester method certainly does, would be to drive the water forcibly forward into the minute bronchial tubes, and into the air-cells, giving rise to a spongy or doughy feeling instead of the natural light elastic crepitation of healthy lung tissue. Moreover, the water becomes inspissated with mucus, and frothy, by mingling with the air remaining in the lung; an exaggerated condition of what I have shown produces, in apoplexy, "mucous stertor."

It must have surprised the Committee to have found their results, although confined to animals, so entirely opposed to those of Sir Benjamin Brodie, and caused them to wonder how such differences could have arisen. It occurs to me that Sir Benjamin, and others at that time, must have drawn their conclusions from the fact that at times, in drowning, no water was found in the trachea and larger air-tubes; this, however, could not be so surprising when we reflect how easily water will make its way out of the trachea and large tubes during the many and irregular movements to which the body is being subjected whilst being removed from the water to a suitable place for treatment, and, further, when we reflect how rapidly water evaporates on exposure to the air. At all events, it is now quite certain that the previous observers were in error. In

1862 I had a case of drowning, and observed it very carefully during the whole course of its treatment. I made it, in fact, the subject of an experiment, and I found that for three quarters of an hour a little fine white foam was expelled from the mouth or nostrils at each pronation of the body. A second case soon followed, and my observation of it gave precisely similar results. I then critically examined the many cases of drowning reported by Professor Casper, and in nearly all of them was to be found most positive evidence that the lungs of the apparently drowned were gorged with water. He says (vol. ii., p. 238, *et seq.*, New Sydenham Society's edition):—

“In the recent bodies of those who have been suffocated by drowning we find, besides the cinnabar-red, vascular injection of the tracheal mucous membrane, sometimes only a few isolated, white, but very distinct, small, pearl-like bubbles; sometimes a much greater quantity of froth, which is generally white, and more rarely bloody, and sometimes the whole tracheal canal is completely filled with this finely vesicular white foam. This extends into the bronchi, or rather, extends out from them and their ramifications, as is distinctly evinced by exerting strong pressure on the as yet untouched lungs, when this froth will be seen to ascend into the opened trachea, even in those cases in which little or none of it had been originally found.” . . . “I have found,” he says, “this appearance in the trachea” (in those entirely submerged from the first), “precisely the same as in those other cases in which a repeated emergence above the surface of the water, though not positively known, might yet have been supposed to have taken place. At all events, since this froth is the product of the mixture of the inhaled fluid, in which the drowning has occurred, of the natural mucus of the passages, or even of blood from some ruptured vessel with the air contained in the lungs and trachea, and caused by the final forcible respiratory movements, it must be regarded as an indubitable sign of vital reaction—that is, that life must be regarded as having existed at the period of its formation.” . . . The lungs completely distend the chest, “they appear to be inflated like a balloon, and are not like ordinary healthy lungs, tolerably firm and crepitating, but feel exactly like a sponge. A similar condition is not found so constantly after any other kind of death, excepting only the most acute œdema of the lungs, which, however,

is not present in this case, and, occasionally, after suffocation in irrespirable gases. The distension of the lungs is in part an actual hyperæmia, in consequence of the most violent inspiratory acts carried on at the momentary emergences of the head of the drowning person above the surface of the water, but partly and chiefly a consequence of the inhalation of the fluid, in which drowning occurred, into the lungs, as has been indubitably proved by experimenting on animals with coloured fluids, and by my own experience in regard to specific fluids. When the lungs are incised there is a copious outflow of sero-sanguinolent froth.

“The fact, proved by experiment beyond the possibility of a doubt, that the increased volume of the lungs does not exclusively depend upon mere hyperæmia, explains why this condition of the lungs is found even in those cases of drowning where death has been caused, not by asphyxia, but by neuromyolysis, and this adds very much to the value of this most important appearance.”

Such was the experience of Professor Casper, and, it may safely be assumed, of the profession in Germany generally. Such, too, was the experience of the French school and of Mr. Blackett, the police surgeon to the Hyde Park district.

We have then arrived at this position :—

(1) It has been demonstrated that water always is present in the lungs of animals that have been drowned.

(2) I have adduced living cases, and Professor Casper and other eminent pathological experts have shown in the dead that the same conditions obtain in man under similar circumstances.

(3) I and others have observed and recorded cases in man in which froth and water continued oozing away from the lungs for a long period during the application of the Marshall Hall method.

In 1861, a woman, who had been taken out of the Serpentine and treated by the hot bath at the receiving house, was taken to St. George's Hospital about one hour afterwards. Mr. Jones, the resident medical officer, states that on admission “her breathing was fair, with loud rattling noise; her lips were livid, her pulse *very good*, her surface and extremities very cold; she was sensible and able to speak.” Warmth and appropriate measures were employed, but in half an hour Mr. Jones was suddenly summoned, and only arrived to see her draw her last breath. The Marshall Hall method was

immediately employed for half an hour, without the slightest signs of recovery, *but a large quantity of frothy fluid* came from the mouth. At the *post-mortem* examination next day it was reported that "both lungs contained an immense quantity of frothy fluid, the bronchi were filled with fluid and injected." In this case the lungs were loaded with and paralysed by water. There cannot be a doubt that the Marshall Hall method would have unloaded the lungs, but I cannot doubt, also, that had she been placed on one side on her arrival at the hospital, the upper lung would have cleared and acted quite sufficiently to sustain life. A lung containing frothy fluid does not clear immediately; the bells of foam must gradually coalesce and ooze slowly away, and to assist this nothing is more adapted than the Marshall Hall method.

Dr. Trollope, of St. Leonards, was called to man who had been taken out of the sea. The man could speak a little, and vomited a quantity of water; but he rapidly became worse, insensibility came on, the breathing was slow and faint, and the pulse flickering.

The Silvester method was being used, and Dr. Trollope persisted in it for some minutes. "Meanwhile," Dr. Trollope reports, "his respiration had ceased, beyond a slight mucous rattle in the wind-pipe; his heart's action could not be felt; jaws clenched and lips livid. . . I then, finding these alarming symptoms supervening, in spite of the persistence in Dr. Silvester's method, immediately had recourse to Dr. Marshall Hall's prone and postural, or 'ready' method, and was gratified to find *fluid escape from the mouth each time the body was laid on the chest*, and respiration gradually set up, commencing with long-drawn respirations, or rather gaspings, at intervals. I persevered in the prone and postural movements for three-quarters of an hour, till respiration was thoroughly and satisfactorily established. The man then again vomited between a pint and a quart of water, and was afterwards able to swallow a few tablespoonfuls of tea, and went on satisfactorily." A most characteristic illustration of what must always obtain in such cases.

In March, 1862, I was called to a man who had been knocked into the sea by a heavy chain. On getting him ashore he was believed to be dead, but one of the men thought "they ought to get the water out of him," and so proceeded to roll him from side to side, and whilst this was done, a quantity of water *was* expelled from the mouth, and they perceived some attempt at breathing.

A few minutes after this I was on the spot, and found the man apparently dying, making occasional and feeble attempts to breathe, with a very feeble and irregular pulse. He was lying on his side with his head upon a coat, and a quantity of froth tinged with blood was lying on the coat in the neighbourhood of his mouth. I observed that clear water and froth welled out of his mouth at the end of every inspiration. Active friction of the limbs, hot bottles, and hot bricks were carefully applied, and ammonia to the nostrils. Nearly an hour elapsed before we thought it possible he could live. He then began to moan, and in a short time a small quantity of brandy was swallowed, and he slowly recovered.

In July, 1864, a man was capsized in a boat at sea. After being in the water some time he was picked up and rowed ashore. On arrival he was cold and livid, but breathing with great labour. He was immediately turned on his side by the coastguardsmen, and a quantity of frothy fluid came from the mouth. He was taken to an inn, where he was kept on his side, and where I saw him a quarter of an hour afterwards. He was then breathing with difficulty. A fine white froth, almost like milk, was oozing from his mouth and nose; his face was very livid, and meaningless in expression; his breath was cold; the pulse could not be felt. There were a few moist râles in the left side of the chest, the side which was uppermost, but the breathing was tolerably free; the breathing on the side upon which he lay was very feeble and obscure, and moist râles were more abundant. He could not be roused. In half an hour he became a little restless, and then vomited a quantity of sea water. The pulse could now be felt, but not counted; this gradually improved. Attempts at vomiting supervened, and occasionally a partial restoration to consciousness. After another attack of vomiting, the pupils, which had been widely dilated, became contracted, and he went off into a sound sleep. He passed a most trying night from restlessness and pain at the epigastrium; and the next day he was still livid, but better and easier. The following day pleuro-pneumonia of the right side (that which was downwards) supervened. From this he slowly recovered.

The following extract from a letter from Dr. Colbeck, of Dover, is corroborative and worth relating:—

“Some years ago I had a case of drowning at the Sailors’ Home,

in which I distinctly made out water to be present in the lungs, as there were loud mucous râles throughout both lungs; after long and persevering efforts with the Marshall Hall method, I succeeded in resuscitating the man. During the whole period some water flowed from the mouth, much of it doubtless from the lungs, as it was very frothy. He had a severe attack of broncho-pneumonia subsequently, and was very ill, but from this he also finally recovered."

On August 11, 1871, I was summoned to a case of drowning. I found a young man, about 19 years of age, lying on his back on the beach and men engaged rubbing his limbs.

The face was livid, and there was froth about the mouth and nostrils, the eyes were opened, conjunctivæ congested, and pupils dilated and fixed; there was no pulse, no respiration, nor other sign of life. On percussion both sides of the chest were dull, but less so in the subclavian regions.

The patient was turned on his face, and a quantity of clear water and froth issued from the mouth and nostrils; he was then turned on his side, and the Marshall Hall method continued steadily for three-quarters of an hour; up to the last a little froth issued from the nostrils when pressure was applied to the spine in the prone position. From time to time I examined the chest, and found the upper (right) lung gradually clear; until at last it gave forth quite a natural resonant sound on percussion, whereas the lower lung remained perfectly dull.

After using the Marshall Hall method for ten minutes, when I thought most of the water had come from the upper lung, I had the upper arm (for the patient was kept on one side, the left, the whole time) raised up over the head, in the manner described by Dr. Silvester; more air now appeared to enter the tubes, and froth was, on compression of the thorax when the body was pronated, expelled. I could hear râles in the chest during the artificial respiratory movements. The face became less livid, and this was the only apparent change which occurred during our efforts. The temperature of the body was sufficiently preserved by the heat of the sun. I had no galvanic apparatus at hand. On careful inquiry there is no doubt that the patient had been under water for twenty minutes, for he was bathing half a mile from the town, and this distance had to be traversed and a boat rowed to the spot before assistance could be afforded. He was found near the bottom face

downwards, in a sort of stooping position, and rose steadily to the surface when an arm was placed beneath the body.

This case, although unfortunately unsuccessful in its results, was most valuable as an experiment; like others I have seen before, it affords proof that water *does* enter the chest, and that before air can be introduced the water must be removed; for this purpose no method hitherto suggested can equal the Marshall Hall method, as it is both simple and certain to effect its object. Moreover, it proves that the application of the Marshall Hall method, for from two to five minutes, will not suffice to clear the lungs.

A case almost identical with the foregoing was under the joint care of Dr. Tyson and myself. The young man, aged 20, had been in the sea submerged for about the same time, the appearances were similar, a similar treatment was adopted, similar changes took place in the lungs during the treatment, and the froth continued to ooze from the mouth about the same length of time. Both cases were carefully observed, and might be fairly looked upon as experimental and scientifically accurate.

The following case has been kindly supplied to me by Dr. Tyson:—

A man, aged about 40, was brought into the Folkestone Hospital. He had fallen into the harbour, and was believed to have been in the water from ten to fifteen minutes. On admission he was very cold and in a collapsed condition. There were feeble attempts at respiration. The Marshall Hall method was immediately applied, and continued for thirty minutes.

During its employment the man was always kept on one side, and was turned from face to side from sixteen to twenty times in the minute. Sea water of a frothy character escaped from the mouth during each expiratory action for twenty minutes or longer. The man was manifestly better for the treatment adopted, but it was not considered safe to discontinue the artificial respiration for at least half an hour. The man eventually made a good recovery.

These examples, with many others that I could relate, observed by others as well as by myself, show conclusively that in cases of drowning in man, water *does* exist in the lungs; that the water only very gradually, and after a long time, is effectually expelled; and that it is unreasonable to expect that relief should be afforded in water-logged lungs by the Silvester method alone.

(To be concluded.)

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY DR. GOODHART.

THE cases which attended at Dr. Goodhart's consultation were the following :—

I.—A girl, aged 17, with enlargement of the glands in both arm-pits, and the sinus of a strumous abscess over one hip. There was no enlargement of cervical glands. The diagnosis of Hodgkin's disease in association with tuberculosis was given.

II.—A case of cellulitis following the bite of an insect. The patient was a young man of 22, whose hand had been bitten in Epping Forest a few days ago. There was great swelling and tension, and bullæ had formed. Rest in bed with the arm elevated, and a hot boric acid fomentation, were ordered.

III.—A woman, aged 50, who was the subject of heart diseases, and had also symptoms of gall-stone. In commenting upon this case, Dr. Goodhart made some important remarks as to the medical treatment of gall-stone cases. He spoke highly of the value of olive oil, and said that 2 ounces a day might be given and that very large doses were not necessary. The oil was best given with a squashed orange. He had known cases in which malignant disease was suspected clear up under this treatment.

IV.—A waterside labourer, in whom the symptoms of thoracic aneurism were present. He had been ill eighteen months, and had shortness of breath and a brassy cough. There was no history of syphilis.

Dr. Goodhart, after commenting on the physical signs, gave the diagnosis of an aneurism of large size involving the whole aortic arch. As to treatment, he recommended iodide of potassium as likely to ease pain by diminishing tension, but denied that it had power as a blood-clotting agent. A very quiet life was, of course,

essential, with possibly rest in bed. The man should have plenty of solid food, but should drink sparingly. Calcium chloride might be beneficial.

V.—The last case was one of mitral stenosis, which presented some interesting points for the stethoscope, but does not call for further notice.

BY DR. SHARKEY.

At Dr. Sharkey's consultation the following were the principal cases :—

I.—A man, aged 20, who was the subject of emphysema, with also a cavity in the left apex. He was an under-sized man and of cyanotic aspect. In giving the diagnosis of general emphysema, Dr. Sharkey said that the indications of a considerable cavity in the left apex were yet quite clear, although dulness was absent. There were bubbling râles and whispering pectoriloquy. He hesitated to pronounce the cavity tubercular as the sputum had not been examined microscopically.

II.—A girl of 24, with supposed atrophic wasting of the muscles of face and chest. Doubt was expressed as to whether the case could be regarded as one of primary muscular atrophy. Although apparently much wasted, the muscles retained their activity.

III.—A man, aged 60, in whom partial thrombosis of the superior vena cava was diagnosed. His first illness had begun two years ago, and had been attended by pain, shortness of breath, and general anasarca. The result had been that the superficial veins of the chest and abdomen had been left much enlarged. They filled from above downwards.

Dr. Goodhart remarked that there was no room for treatment, as the disease which had caused the condition was at an end. As the urgent symptoms had long subsided, he saw no reason why the man should not resume light work.

IV.—A woman, aged 50, complaining of great debility, and with a pigmented skin. In this case the diagnosis of Addison's disease was discussed.

V.—A large part of Dr. Sharkey's consultation was occupied by an important case of bilharzia hæmatobia, which he had himself brought.

OPHTHALMIC CASES.

BY MR. TREACHER COLLINS.

The following cases were shown by Mr. Treacher Collins at a Consultation held at the Polyclinic on October 12, 1900.

I.—A lad, aged 19, who had had a perforating ulcer of the cornea of his left eye, in connection with gonorrhœal ophthalmia, in December last year. On April 11, 1900, the operation of evisceration was performed, with the insertion of a glass globe into the emptied sclerotic, which, together with the conjunctiva, was stitched over it (Mules' operation). The day following the operation his temperature was 100° , but it never went higher. The lids and conjunctiva were for a few days much swollen and œdematous. This swelling gradually subsided, and on April 26, the wound being healed, the stitches were removed and the patient discharged from the hospital. He was now wearing his glass eye, and he was exhibited to show what an excellent appearance it presented. It was fully as prominent as the other eye, and the movements vertically were quite equal in the two. The lateral movements, however, of the glass eye were somewhat restricted. The glass eye was taken out to show the stump formed by the sclerotic surrounding the glass globe or "artificial vitreous."

II.—A man, aged 55, who first presented himself at the hospital on August 16, 1900, saying that a month previously he had an attack of neuralgia in his left brow, and that then some spots appeared on it which he thought were due to mosquito-bites. A fortnight later the left eye became painful, and he noticed a mist in front of it. He was not subject to neuralgia, and he knew of nothing which could have given rise to the attack. He was subject to gout.

On examination, the scars of recent herpes were seen on the left side of the forehead and strictly limited to it; there were none on the nose. There was some haze of the cornea, and on magnification some minute vesicles could be seen on its surface. There was ciliary and conjunctival injection. Later the iris became much discoloured, and an ulcer formed in the cornea with some yellow infiltration around. The tension became subnormal. The patient had been treated with warm boric acid fomentations, atropine and iodoform ointment, and a pad and bandage.

When shown, the scars of the herpes could still be seen.

The eyelids and skin around were red and much swollen, due to irritation caused by the atropine.

The ulcer of the cornea had nearly healed, but there was still some infiltration, and there was still iritis.

III. and IV. were cases of trachoma and pannus in different stages. In one there were a large number of trachoma follicles present on the inner surface of the upper lid and in the retro-tarsal fold of the left eye. In the right eye they had recently been squeezed out with a pair of Grady's trachoma forceps. In both eyes the upper two-thirds of the cornea were involved with pannus. In the other case the inner surfaces of the lids were smooth, but extensively scarred. Only a few blood-vessels were left coursing over the upper part of the corneæ. The characters which these cases presented were contrasted with those seen in two cases of follicular conjunctivitis shown at a previous consultation.

V.—A girl, aged 12, who about five years previously had had acute inflammation of both lacrymal sacs, following an attack of scarlet fever. From the right ever since there had been a mucopurulent discharge. The canaliculus had been slit and the duct dilated with probes, but the stricture had again contracted and the discharge had continued. The patient was very timid and nervous. It was impossible to do anything with her without an anæsthetic. It was therefore decided to excise her lacrymal sac. On July 9, 1900, the operation was satisfactorily performed, but attended with some difficulty, due to the constant oozing of venous blood. The wound healed readily after the operation. The patient was exhibited to show how little scarring had resulted, and how little inconvenience was attended by complete absence of any drainage apparatus connecting the eye with the nose. Close examination was required to detect which side had been operated on.

The patient stated that, in the ordinary way, there was no overflow of tears. If she was exposed to a cold wind, she said, her eyes watered a little, but she thought the eye on the side unoperated on watered more than the other.

VI.—A little boy, aged $3\frac{1}{2}$, with a pear-shaped congenital coloboma of the iris downwards in the left eye, unassociated with any coloboma of the choroid.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. JONATHAN HUTCHINSON.

(Continued from page 243.)

Some weeks ago two cases of great interest in connection with tropical medicine were brought before us in my surgical clinic by Dr. Patrick Manson. On one of these I wish to say a few words.

The case I allude to was an example of *filarious lymph tumours in the groins*. The patient, a man of about 26, apparently in good health, had no trace of elephantiasis anywhere. In his groins, however, were large conspicuous tumours, consisting not of glands, but of enlarged lymphatic trunks. These tumours crossed the upper part of the Scarpa's triangle in a direction parallel with Poupart's ligament. They consisted of lymphatic trunks, enlarged to the size of the forefinger and much convoluted. They were not adherent to the skin, nor was the latter in the least reddened. The outlines of the several trunks could easily be distinguished, and excepting that they were much more solid, they closely resembled varicose veins of large size. It was not, however, practicable to materially diminish their size by pressure. In the recumbent position they became somewhat smaller. Their limitation to the region of the groin was very marked. It was not possible to trace the trunks down the thigh nor upon the abdominal wall. There appeared, however, to be communicating trunks crossing over the pubes, but they were concealed by the thick skin. Nothing that felt like a solid gland could be distinguished on either side; as has been said, the tumours were large enough to be easily visible as the man stood before us. Dr. Manson said that he proposed to have the masses excised, and said that he felt sure that filaria would be found in the fluid contained in the lymph-varices. He suggested that very probably there was obliteration of lymph channels within the abdominal cavity, and that these varices resulted from it.

I expressed surprise that the patient had no elephantoid hypertrophy of either scrotum or legs, having been under the impression that these dilated varices in connection with the filaria were usually secondary to elephantiasis. Dr. Manson assured us, however, that in tropical districts it was not unusual to see cases like the present

wholly without disease in the skin itself. It was, he added, a remarkable fact that in these cases, as in elephantiasis, the patients were liable to periodic accessions of febrile disturbances with a certain amount of swelling and pain in the varices. These had been experienced by the patient before us.

Consultation Cases, September 27.

The cases which were brought before us on September 27 were the following :—

I.—Central scirrhus of breast. (Dr. Blake.)

II.—Peripheral scirrhus of breast. (Dr. J. A. B. Thompson.)

III.—Ulcerated gumma of tongue in a girl of 18 (congenital syphilis?). (Dr. Greenwood, Enfield.)

IV.—Lymph adenoma of the acute type in girl of 14. (Dr. Willey.)

V.—Lympho-sarcoma with subcutaneous infection, beginning from inguinal glands. (Dr. E. Graham Hodgson, Chertsey.)

VI.—Cancer of tongue in a very early stage. A man of 60. (Dr. Aird.)

Two Cases of Cancer of the Breast.

One of these presented in a most typical form the well-known symptom of retraction of the nipple. The nipple, still quite sound, was sunk in a funnel of depression. In this instance the tumour, of stony hardness, was in the middle of the gland. In the other patient the nipple was not in the least retracted, but over the axillary border of the breast, which was plump and full, there was a visible dimple. At this spot the skin was adherent to a hard mass beneath. I remarked upon the significance of the retracted nipple, stating that it was to be expected only in cases in which the tumour was situated centrally. In both cases an immediate operation was advised, the entire breast to be taken, and the axilla cleared. In both there was a family history of cancer. Both were women of about 50 years of age.

Consultation Cases, Thursday, October 4.

The cases which attended for consultation on Thursday, October 4, were the following :—

I.—A case of “Sycosis-keloid,” affecting the nape and the greater part of the scalp in a negro. (Mr. Hitchins.)

II.—A case of gangrene of the toes in a diabetic man, showing sound healing after amputation. (Mr. Milburn.)

III.—A woman of 53 with a sarcomatous growth from the upper maxilla. (Dr. Thompson, of Abridge.)

IV.—A young man whose portrait had been taken two years ago as an exceptional form of iodide acne (given below.)

Acne probably from taking "Clarke's Blood Mixture" (iodide of potassium).

The subject of this case was a young man whose eruption had excited great interest at a former consultation more than two years ago (June, 1898). On that occasion a photograph was taken which has been placed in the museum. His cheeks, nose, chin, and forehead, were then covered by a florid acne-like eruption which he assured us was of only a month's duration. There were no comedones and no pustules. All history of drug treatment was denied, and the man appeared to be in good health. Setting aside the suspicion of a drug-eruption, the diagnosis seemed to rest between adenoma sebaceum and an acute form of acne. On the present occasion the man attended at request in order that he might be confronted with his photograph. Every trace of the eruption, excepting some small depressed scars which were quite pale, had disappeared. His account was that the eruption had faded away almost suddenly, about a month after our first consultation and whilst he was staying at the seaside. The completeness of the cure again raised the suspicion that it must have been of drug causation. In answer to my pressing questions, the man now admitted that he had taken a few doses of "Clarke's Blood Mixture." He had no eruption before he took it, and had no special reason for taking it, "but it was in the house." He thought that he took only two doses, and that the eruption remained out for at least two months after he left it off.

Consultation Cases, Thursday, October 11.

The cases which attended at the surgical consultation on Thursday, October 11, were the following:—

I.—Case of secondary syphilis of throat and mouth which had resisted treatment. (Dr. Blake.)

II.—Large osteoid tumour on right parietal bone of nearly ten years' duration in a healthy man of 34, following a blow; painless, and without cerebral symptoms.

III.—Herpes frontalis, with implication of the oculo-nasal nerve and eruption on tip of nose and inflammation of eye.

IV.—Gumma of tongue in congenital syphilis. (Dr. Greenwood.)

V.—Severe eczema of legs, with acne of face and feeble circulation.

VI.—Large umbilical hernia in an infant, with separation of the recti and weak linea alba: in a female child. (Dr. Dixon.)

At the conclusion of the consultation I made some clinical remarks on gangrene in diabetes, and on the diagnosis of iodide and bromide acne from acne varioliformis and syphilitic eruptions.

LARYNGOLOGY AND OTOTOLOGY.

BY STCLAIR THOMSON, M.D., F.R.C.S.

Friday, September 28, 1900.

REMARKS ON "BLACK TONGUE" AND OTHER CASES.

THE designation of black tongue is not altogether a happy one for this condition, as the whole tongue is never affected in any case, and it is seldom that the colour is decidedly black. In most cases the tint is rather brown, or yellow, or simply dirty gray. But the alternative name of hairy tongue (the *langue pileuse* of the French and *Haarzunge* of the Germans) is also misleading, as there is no true formation of hair, however like it the appearance may be. Amongst other titles which have been suggested are nigrities, parasitic glossitis, hyperkeratosis linguæ, lichenoid, and glossophytia.

The name black tongue has become established by use, although it might be maintained and improved upon by adopting the title employed in the last edition of Butlin's "Diseases of the Tongue,"¹ viz., the hairy black tongue.

The case shown illustrated all the typical points of this singular affection. The patient had been attending Dr. StClair Thomson for an affection of one tonsil, and had been advised to neither smoke nor drink. After abstaining from both these habits for some weeks

¹ London: Cassell & Co., 1900.

he came to report himself as better in so far as the tonsil was concerned. He made no complaint about his tongue, and yet the centre of it was found to be symmetrically occupied by the affection known as "black tongue." In front of each arm of the V formed by the circumvallate papillæ, and stretching some way forward in front of the foramen cæcum was a raised mass of what appeared to be of the consistence of pulpy cream. It was widest about the centre of the tongue, and tapered off to a point as it passed backwards and outwards in front of each arm of the V, and forwards along the middle line of the tongue. The mass had, therefore, the outline of a three-cornered hat. It was raised a quarter of an inch to three-eighths of an inch above the surface, being highest in the centre and diminishing on each side. The colour was shaded in the same way, being blackish-brown where the new growth was thickest and most central, and passing through yellow to dirty gray as it approached the margins. At first sight it appeared like the ordinary dirty coated tongue, but on looking carefully it was seen that the raised mass was composed of a large number of short hair-like fibres, with a thick sort of magma between them. These hair-like processes were all inclined forward, and have been compared to a field of wheat bowed before the wind. With a probe they could be swept in an opposite direction, just as one can reverse the nap on a silk hat; but they also resembled the nap of the hat in that only one certain inclination was natural to them. When seized with a pair of forceps it was easy to remove a tuft of these "hairs." Some of these were handed round, and it was seen that most of them were about a quarter of an inch long, some were slightly curled, and they could be compared to the fibres of moss, or tendrils, or certain seaweeds, or horsethair; while others were almost as fine as the down on the face. Some were at once stained by the medical superintendent (Captain Pinch), and under the microscope it was seen that each "hair" consisted of a hypergenesis and a hyperkeratosis of the epithelium of the filiform papillæ. Each thread or hair was then seen to be coated with a number of keratinised epithelium cells, partially detached at one end. In this way the hair presented somewhat the appearance of the stem of a palm tree, or of the stalk of a feather, or of a pine cone in which the scales are bursting away.

As this case well illustrated, the disease causes no symptoms. This patient was quite unaware of its presence. It could not be ascribed to abuse of alcohol or tobacco, for he had abandoned both some time before the black tongue appeared.

The colour is ascribed by Butlin¹ to the organisms which cling to the papillæ. On the other hand, Maraval² has tried in vain to isolate a parasite which would produce the black colour. Hallopeau attributes it to an exaggeration of the brown tint normally present in epithelium cells. Mr. Hutchinson has suggested the possibility of the stain being produced by some chemical agent. Careful inquiry appears to have excluded such a cause in this case. The patient had used nothing but a mouth-wash of chlorate of potash.

The duration of the affection may extend from a few weeks to as many months. It hardly calls for any treatment, and as it is apt to be resistant to interference, it seems wisest to explain to the patient the nature and slight importance of the affection. If he insists on an attempt to free him from the condition, the "hairs" might be plucked off, and their bases painted with a 5 per cent. solution of chloride of zinc or a 2 per cent. solution of salicylic acid.

PROGNOSIS IN SOME FORMS OF DEAFNESS.

It takes a long and careful examination to decide, first the form of disease causing deafness, and, secondly, the probability of giving relief. In some cases the latter can only be decided after some attempts at treatment. Yet the prognosis is not only the point of the greatest interest to the patient, but also is the one on which the aurist's skill and reputation are most frequently founded.

A case was shown illustrating some important features bearing on the above remarks. The patient had been getting—at first slowly, then rapidly—deaf; his tympanic membranes were quite normal in appearance; his hearing of the tuning fork through bone was diminished; and he heard better in a noise—the so-called paracusis Willisii. Without going completely into the case, these points were indicated as showing a condition which was almost hopeless. As a rough rule, it might be taken that the more normal the appearance of the drum the less hopeful is the prospect.

¹ *Loc. cit.*

² *Revue de Laryngologie*, September 8, 1900.

REVIEWS AND NOTICES OF BOOKS.

THE SIGNS AND SYMPTOMS OF PLAGUE. By James Cantlie, M.B., F.R.C.S., D.P.H. (*Ordered by the Public Health Committee of the London County Council to be printed.*)

Amongst the various measures which, with praiseworthy zeal, the various authorities have taken in order to prevent the introduction of plague into London, none have been more judicious than the selection by the London County Council of Mr. Cantlie as its adviser. By special arrangement Mr. Cantlie's services have been placed gratuitously at the disposal of any medical man who may be consulted under circumstances involving suspicion. This arrangement cannot be made too widely known. The paper which we have now under review is one which has, at the request of the London County Council, been prepared by Mr. Cantlie in order to supply information on the subject. As it contains a summary of the most recent knowledge from the pen of a writer of wide personal experience, we shall extract from it, at some length, those parts which are likely to be of most interest to our readers.

Beginning with a general statement as to the nature of plague, Mr. Cantlie proceeds to group its varieties as follows :—

“(1) *Bubonic plague* is characterised by the development of a bubo or buboes during some period of the attack. It is by far the most common variety, buboes seldom occurring in less than 70 per cent. of the cases met with during an epidemic.

“(2) *Septicæmic plague*.—No bubo occurs in this variety of the disease. During life the glands may be felt enlarged to a small extent in exposed parts, but *post-mortem* examination shows every gland to be swollen to some extent. Septicæmic plague is very fatal.

“(3) *Pneumonic plague*.—As the name implies, the lungs are primarily affected, and so far as can be elicited by clinical examination they are the only organs which develop definite lesions. The glands are not enlarged, nor are they found swollen after death. In some epidemics the pneumonic type of the disease is more prevalent than in others. Patients with plague pneumonia seldom recover.

“(4) *The nervous type*.—When delirium, mania, convulsive seizures, aimless wanderings, tremors, deafness, dumbness, &c., constitute prominent features of the attack, they are sometimes referred to as belonging to a nervous type of the disease. Convulsions in children and delirium in adults may usher in the disease. In children this is a fact to be remembered, as the convulsions may continue to occur and the child die before other symptoms suggesting plague have developed.

“(5) Such terms as *toxic* and *fulminant* as applied to plague imply a rapidly fatal issue, the patient succumbing within twenty-four hours; so sudden is the onset and development that the system seems paralysed in its effort to attain a reaction; the pallor of the face, the prostration, the low temperature, and the

feeble pulse would seem to indicate that the person attacked is struck down as if by severe shock.

“(6) Cases of plague are referred to a *puerperal* type when abortion or miscarriage has occurred. Hæmorrhages from the uterus and appendages occasionally occur independently of pregnancy. Women in the later stages of pregnancy abort when attacked by plague. After abortion due to plague few women recover.

“(7) *Pestis ambulans* indicates a mild type of the disease in which the patient may go about his ordinary duties. The buboes may give rise to no inconvenience and no feeling of illness. It is most commonly met in children. Several members of the household may be attacked severely by plague, but one child may escape with a painless swelling merely. This is a very dangerous type so far as infection is concerned, and a careful watch must be kept on the possible development of such cases.

“(8) *Pestis minor*.—What is termed the larval or abortive type of plague, but which is perhaps best designated *pestis minor*, is an interesting form of the disease from every point of view. During many epidemics of true plague observers have recorded a mild form of the disease, which occurred not only when the epidemic was at its height, but which for several months (or years) before, and for several months (or years) after, spread among the community.

“The importance of this ailment is that it may precede an outbreak of plague, and should be carefully watched and recorded. The symptoms are swelling of a groin gland, inflammatory effusion in the periglandular tissue, some initial fever and gradually-increasing temperature, and a feeling of general *malaise*. The skin over the bubo reddens, suppuration develops, and the pus finds its way to the surface by two, three or more fistulous openings. The gland when excised is found surrounded by a thin purulent fluid, and when a section is made several small necrosed or purulent foci are seen to stud the gland tissue, which has become soft and diffuent. After removal of the gland the parts gradually heal, and by the end of a month, with the exception of a scar, all traces of the disease disappear.

“In Calcutta the plague bacillus was reported present in cases of *pestis minor* amongst soldiers of a regiment which arrived in Calcutta from Hong Kong whilst plague was raging in Hong Kong. It is important that cases of so-called *Bubon d'emblée*, that is, buboes occurring independently of a venereal cause, should be carefully examined for plague bacilli when plague threatens or is prevalent.

“THE PLAGUE BACILLUS.—MICROSCOPIC CHARACTERS.

“When from within a gland, or from the periglandular tissues, a small quantity of fluid is drawn off by a hypodermic (or antitoxin) syringe and examined, bacilli will be found plentifully distributed in the fluid. In the blood the bacilli may not be found until late in the disease. Search may also be made for the bacillus in the fæces, in the urine, or in the sputum of pneumonic cases. In the pus of recently opened buboes, or in the scrapings from the surface of an incised gland, a luxuriant crop will usually be found. Old-standing purulent discharges seldom show the bacillus. *Post-mortem*, almost every organ of the body shows the presence of micro-organisms. They may be readily demonstrated when a smear from any of these sources is spread on a slide, allowed to dry, and a staining fluid added. The stain may be any one of the basic aniline dyes. The plague bacillus is a short thick rod, with rounded ends. In length it measures about $1.5\ \mu$ and in breadth $0.7\ \mu$. The ends of the rod-like bacillus stain much more deeply than the centre, and around the stained portion a clear area or envelope is sometimes to be made out.

“*The means by which plague is spread.*—Plague is spread chiefly by human agency; but rats, body and household parasites, wounds, food and drink, and infection by the air are all possible agents in the spread of the disease.

“Contact with plague-infected persons may or may not directly influence infection by plague; all depends on the circumstances and environment. Doctors, nurses, and attendants in hospitals are not markedly subject to attack, in fact the plague hospital seems to be the one place in a plague-stricken city where contagion is least potent. This is to be accounted for by the cleanliness of hospitals and by the care taken to disinfect clothing, bedding, utensils and excreta. In uncleanly abodes where disinfection, &c., is not practised, contact with persons sick of plague is dangerous in the extreme. Plague germs leave the body by way of the respiratory tract, by the fæces and by the urine. The sputum is the most directly infectious of all these, but the excreta are more likely to convey the bacillus either by soiling the clothing, the bed-room furniture, or by inoculating rats and other vermin.

“Fæces are found to contain plague bacilli for four weeks after the crisis of the illness has passed, and the danger of convalescent patients mixing with the community is thus readily understood.

“Clothing soiled by vomited or expectorated matters, by fæces or urine, retains infective powers for some time (months) if packed away whilst yet moist.

“Food, such as grain, fruit, &c., has been found impregnated with plague bacilli, but proof that food or water has directly conveyed infection is wanting.

“*Rats* are very prone to plague. The first warning that plague is incident may be deaths among rats. Plague-infected rats leave their runs, they appear dazed, become seized with convulsions and speedily die. Whether the rat is seized with plague before man and thus infects him, or whether man infects the rat, is a question as yet undecided. Many epidemics are believed to have been traced to rats, yet in other localities, and markedly so in Glasgow, the rats have not been found infected by plague, either before or after the outbreak. It is by the vermin in the rat's coat that infection is probably conveyed to man. The vermin leave the rat soon after the animal dies, and as it is found that the vermin contain the bacilli, the poison may gain entrance to the human body by vermin bites or by the abrasion of skin consequent on the scratching they induce.

“*Parasites*, such as fleas, bugs, and lice, acquire the bacillus from feeding on plague-sick persons, or they may gather it from clothing, bedding, &c., soiled by excretions.

“Infection by the air is open to question, as although the bacillus has occasionally been found in the dust of rooms, on earthen floors, and even on the walls, it has never been isolated from the air. It is conceivable, however, that in an ill-ventilated room the atmosphere may become so impregnated with the emanations from the sick as to become infectious of itself.

“*Entrance to the body.*—The plague bacillus may gain entrance by the skin, and possibly by the breath and the mouth. Entrance by the skin is considered probable for several reasons. In the first place it is the groin (femoral) glands that are most usually the seat of buboes. The selection of this group is frequently attributed to the fact that the majority of persons affected by plague in warm countries go bare-footed. Against this conclusion are the facts that skin abrasions are but seldom found, and that persons not going bare-foot have their groin glands most frequently attacked. The axillary glands, affected by way of the hands, would *a priori* seem to be more liable to such a method of inoculation, seeing the hands are exposed, and that soiled articles, dead bodies, rats, &c., are touched by them. Such, however, is not the case. It is possible, however, that if vermin are

the intermediaries of contagion that they could settle more quietly and undisturbedly on the lower extremities, even beneath the garments, than on the more exposed parts such as the hands and face, where they are liable to be disturbed or brushed off.

"Plague has been acquired by *post-mortem* wounds, by the sputum alighting on the conjunctiva, and in many instances the marks of insect bites and scratchings on the lower limbs would point to the skin as being the medium of entrance to the body.

"Cracks in the lips and inflamed tonsils are assumed to be the mode of entrance of plague poison when the cervical glands are primarily enlarged. Proof that the bacillus can be inhaled, or that the body may be contaminated by the alimentary canal, is wanting, and however much these channels may swarm in bacilli, the mere fact does not prove that they were infected directly from without."

The "signs and symptoms" are next discussed at considerable length in reference to the several different forms. A few paragraphs are devoted to the "Duration of the disease," and Mr. Cantlie then proceeds to consider diagnosis and prognosis.

"Diagnosis.

"Conclusive proof that a person is suffering from plague can be arrived at only by proving the plague bacillus to be present in the excretions, in the glands or periglandular effusion, or in the blood. But clinical evidences are usually sufficiently pronounced to suggest that the illness is due to plague. The sudden onset, the marked prostration, the mental aberration, the splitting headache, vomiting and nausea, backache, the rise in temperature, the furred tongue, when taken in conjunction with tenderness and pain in some one of the groups of glands are sufficient to indicate the necessity for a speedy microscopic search for the plague bacillus.

"Pneumonic plague is apt to be regarded as simple pneumonia. The rapidity of the development of all the signs and symptoms are, however, peculiar to plague infection. The early delirium, the early signs of patchy pneumonia, the presence of blood in the expectoration from almost the onset, combined with extreme prostration would seem to indicate a specific form of illness. 'Glandular' fever in children is apt to be mistaken for plague during an epidemic. Convulsions in children may usher in an attack of plague. Typhus fever, although an uncommon disease, presents several of the signs and symptoms characteristic of the plague, but typhus fever develops more slowly; the rash is unlike the plague petechiæ which are occasionally met with; the prostration and the delirium come on at a later stage of the disease. Typhoid fever even may be confounded with what is called the 'typhoid' variety of plague, but a forty-eight hours' study of the temperature will generally suffice to differentiate the diseases.

"Prognosis.

"The chances of recovery in individual cases are well nigh incalculable, as the most favourable appearances are sometimes delusive, and the most hopeless-looking cases may recover. In China, among cases under treatment by Chinese 'doctors,' over 95 per cent. of those attacked died. In India, 70 per cent. of natives who were attacked by plague and were more or less, under European treatment died. Amongst white people the death rate is much less; about 35 per cent. only died in India. In Sydney, 103 persons died out of 303 attacked."

The concluding part of the paper is devoted to the pathological anatomy. The entire essay may be obtained on application to the Public Health Department, L.C.C., 8, St. Martin's Place, W.C.

COLLEGE NOTES.

BY THE DEAN.

DURING the month of September seventeen consultations were held, at which eighty-seven patients were presented for advice. Many of them were examples of rare forms of disease. It is gratifying to find that an increasing number of cases are being sent, but the work would be enormously lightened if the recommendation-letters were sent in advance of the patients. It is obvious that in many cases this is impossible, but where the nature of the illness and the circumstances of the case permit of it, the convenience of such previous notice is sufficient excuse for again referring to the subject.

* * *

THE Clinical Lectures for October were delivered by Dr. Sansom and Sir William Gowers. The subjects of "Aortic Disease" and "Epilepsy" could not have been handled by more competent authorities, and in each case the audience was treated to a comprehensive and masterly survey of a subject which comes within the sphere of daily observation in the life of every actively engaged practitioner.

The points of differential diagnosis were dwelt upon by both lecturers with such emphasis as to impress important clinical truths on the minds of all who heard them, and the hints as to treatment possessed a value which will find a practical application in the future practice of many members of the Polyclinic.

* * *

THE Christmas Term of Practical Classes commences on Monday, November 5th. As will be seen from advertisement, certain changes have been made in the arrangement of the work, but its scope remains the same. The teachers on duty for this term are Dr. Seymour Taylor, Mr. James Cantlie, Dr. Harrison Low, Dr. James Taylor, Mr. Griffith, Dr. Herbert Tilley, Dr. Dundas Grant, and Mr. Hayward Pinch.

The extra-mural classes continue as before.

* * *

A CLINICAL lecture will be delivered on November 7 by Dr. Christopher Childs, on "The Bacterial Purification of Sewage.

especially in relation to the Prevention of Infection by Enteric Fever and other water-borne diseases." On the 21st, Professor Carter, of Birmingham, was under promise to lecture to us on "Dyspepsia from the Standpoint of Modern Methods of Investigation," but circumstances which are unavoidable and were unforeseen have compelled Professor Carter to postpone the delivery of his lecture till after Christmas.

Mr. James Cantlie has very kindly agreed to fill the gap on the 21st, and has promised a lecture on "Plague." The present mild epidemic in Glasgow has called public attention to a disorder of which providentially nothing has been known in this country within the experience of living men, and it is fortunate indeed that the members of the Polyclinic should have this opportunity of hearing its clinical description from one who has had close personal knowledge of the disease in China and elsewhere.

* * *

THE fact that the Clinical Lectures are delivered on alternate Wednesday afternoons is now sufficiently known to make the further issue of reminder-post-cards unnecessary. They will therefore be discontinued, but due announcement will be made of the subjects for the following month's lectures in each issue of the POLYCLINIC, and they will likewise be mentioned in the "Coming Events" column of the *Lancet* and *British Medical Journal*. They are also noted in the Schedule of Consultations and Lectures, which is in the hands of members and is issued to them three times a year.

* * *

THE Finsen light treatment of certain diseases of the skin is making rapid advances in professional favour, and it would seem that some of the results attained within the past three months far exceed in success anything previously accomplished in this country. Mr. Malcolm Morris was good enough, some months ago, to receive a party from the Polyclinic at his studio in Campden Hill and to demonstrate the method of application of this new and promising form of treatment. This visit excited much interest among those who were privileged to form the party, and many of them, as well as others who may wish to make themselves conversant with Finsen's method, will be glad to know that Mr. Morris has kindly agreed to a request that he should repeat the favour. Towards the end of

November or beginning of December a suitable date will be chosen to visit Campden Hill, and those who desire to avail themselves of the opportunity thus offered are requested to communicate with Captain Pinch at an early date.

* * *

At the October meeting of the Council, forty-seven names were approved and added to our list of subscribers and members. This is a cheerful beginning for a new year's work, and is, let us hope, an earnest of more to follow. It is in the interest of every member of the College that our numbers should increase rapidly, and very little effort would suffice to make us four figures deep before Christmas.

* * *

THE Librarian's heart has lately been gladdened by valuable donations of books from the Hon. Rollo Russell and Dr. de Watteville. The College is grateful to such benefactors, one of its chief ambitions being the gradual formation of a comprehensive and useful library. Many valuable and some unique works are already on our shelves, but there is room for almost unlimited extension in this direction, and the Librarian hopes that the acceptable generosity of Mr. Rollo Russell, Dr. de Watteville, and many who have made similar gifts on earlier occasions may strike a consonant benevolent cord in the hearts of others who have it in their power to do likewise.

* * *

DURING the month of September the total attendance at the College reached 805.

* * *

Two of our Committees of Investigation on Special Subjects—those upon Tuberculosis and Leprosy, of which the respective chairmen are Dr. Radcliffe Crocker and Dr. Heron—are about to resume their regular meetings. These Committees have already got through a considerable amount of satisfactory work, and as they are capable of extensive usefulness, not only to the College but to the Profession, members are requested to assist in such ways as lie within their power the investigations which are now in progress. The meetings of these Committees are open to members of the College, who are cordially invited to attend.

DR. MCCALL ANDERSON, the recently appointed Professor of Medicine in the University of Glasgow, has become one of our Vice-Presidents.

* * *

THE third week of October broke the record in the matter of attendances. No fewer than 333 members were present at the afternoon Consultations. We are now rapidly approaching the limit when the question of accommodation will call for serious consideration on the part of the Council.

* * *

CAPTAIN PINCH'S lectures on "The Clinical Examination of the Blood" have been much appreciated. They attracted numerous and attentive audiences. He chose a happy way of putting before his hearers the main facts of a complex subject, which he dealt with in broad outline and illustrated by diagrams and microscopic specimens.

He also gave practical demonstrations as to the preparation and staining of blood films, the methods of ascertaining the specific gravity and determining the coagulability of the blood, the use of the hæmoglobinometer, hæmocytometer, spectroscopy, &c.

His lectures were thus essentially practical and well conceived to meet the requirements of the man engaged in active practice.

* * *

AN open meeting of the Tuberculosis Committee, of which Dr. Heron is Chairman, will take place at 5.30 in the Council Room on Thursday, November 22nd.

* * *

OUR members will be glad to know that Dr. Manson has kindly consented so give a short lecture on "Sprue," after which discussion will be invited. The date will be duly announced.

* * *

DR. G. MANN, Lecturer on Histology at Oxford, will shortly deliver in our College some illustrated lectures on "The Histology, Topography and Development of the Cerebral Nervous System." These lectures will be free to all our members.

CATALOGUE-COMPANION TO THE MUSEUM.

PORTRAITS ILLUSTRATING LEPROSY (LEPRA).



A type illustration of tubercular leprosy in a severe form with ulcerations, &c. On the forehead the thickened skin is mapped out by deep furrows. (From a Bergen photograph.)

In attempting to arrange and describe these portraits, it will be convenient to disuse entirely all terms which imply that there are two or more distinct types or forms of leprosy. That the disease is one and the same, and these so-called different forms are frequently coincident in the same patient, and that still more frequently they occur at different stages in the same case, all will admit. The most cursory glance at our portraits and at the designations which have been attached by their authors to those of them which have been published, will demonstrate that the distinctive epithets "tubercular," "anæsthetic," &c., have been used with vagueness and with somewhat very varying conceptions of their precise meaning. The entire disuse of these adjectives as denoting forms of leprosy which are permanently distinct will be a great improvement. Leprosy is one and the same disease in all countries; it has been so in all ages, and although it may present very different phenomena, its nature is essentially the same in all cases. It is desirable, therefore, to always use its name "Leprosy" or "Lepra," and to append to it any other terms which may be desirable to denote the peculiarities of the case under observation.

The following are some of the groups which, in classifying our portraits, it may be convenient to employ. It is always to be remembered that the grouping of portraits differs in an important circumstance from the grouping of the cases themselves in their entirety. In the portrait we have only the representation of the leper in the condition at the time the portrait was taken, and this may have been only a transitory one. In the grouping of cases and in all statements of statistics as to relative prevalence of the different forms, the whole course of the malady from beginning to end should be taken into account. Unfortunately, this has been but rarely attempted, and in but too many cases authors have been content to name and classify their cases in relation only to the most conspicuous phase assumed by the malady at the date when the portrait or the notes were taken. In many a case, had the narrative been followed up, or even traced backwards to its earlier stages, a change in nomenclature would have been found necessary. The reader is accordingly requested to understand that the following groups are constituted only for the classification of portraits or of patients seen only for a short time, and that

our distinct assertion is that in many cases, at different stages, leprosy displays, not one alone, but most of the phenomena mentioned.

Group I.—LEPROSY with maculæ only and anæsthesia in patches.

Group II.—LEPROSY with neuritis and anæsthesia in definite nerve regions.

Group III.—LEPROSY with both maculæ and neuritis.

Group IV.—LEPROSY with diffuse erythema and thickening of skin and with ill-defined anæsthesia.

Group V.—LEPROSY with tubercles.

Group VI.—LEPROSY with pachydermatitis simulating tubercles.

Group VII.—LEPROSY with ulcerations.

Group VIII.—LEPROSY with mutilations.

It will be recognised that the above grouping involves the belief that leprosy may begin either as a neuritis or a dermatitis. This creed is probably consistent with facts. The anæsthesia of leprosy may result from two different forms of causation. It may follow the disorganisation of a nerve-trunk or that of the nerve-endings in certain patches. In the one case it will be located according to the known distribution of given nerves, whilst in the other it will be in patches, which have no relation in form with any special distribution of nerves. In close connection with the last there is yet a third form of anæsthesia, which occurs chiefly in the extremities, in which the loss of sensation is diffuse, and neither in patches nor in nerve territories, but spreads upwards, and has no definite boundaries. This condition may be termed acroteric anæsthesia or anæsthesia *ab imo*, since it is almost always most definite at the tips of the extremities. It is probably preceded by a diffuse and slightly-marked erythema, but in its later stages may be attended by neuritis of cutaneous twigs. It is sometimes seen as the earliest phenomenon, and is present in almost all cases in their more advanced stages.

If it be necessary to discriminate different forms of anæsthesia, it is equally so to recognise that the term tubercular may be applied to conditions which are by no means always exactly the same. The dermatitis which is the first stage of leprosy in a great majority of cases is usually attended by some thickening of the affected skin. In some

cases this thickening is considerable, and in some regions, more especially on the face and arms, it may elevate the skin into bossy areas which are mapped out by lines of depression. This is the condition which gives the leonine expression to the leper's face and which causes the characteristic deformations of the eyebrows, *alæ nasi*, and lobules of the ears. It might be styled *pachydermatous*, but that the affected portions of skin are soft and flabby, not hard. Innumerable portraits show that this is the state which has usually been styled "tubercular," yet there are no true tubercles, and it is really only a local variety of diffuse erythema with hypertrophy. It is desirable to refuse the name "tubercular" to it because there are other cases in which isolated growths with well-defined bases occur which really claim that term. There are yet other cases in which a macular eruption may be attended with such an amount of thickening of the patch that it may become a question whether the term tubercular may not be applicable. No one can look through our collection of portraits without observing that the term in question has been loosely applied by authors, and further, that with the exception of the comparatively rare cases in which well-defined up-growths are observed it is exceedingly difficult to apply it with precision. It is indeed impossible to say where merely erythematous *œdema* ends and tubercle-formation begins. The considerations just urged add force to the arguments already used against continuance of the attempt to classify leprosy into separate forms as "anæsthetic," "tubercular," and "mixed." No really painstaking observer would find it possible to so group his cases.

Having now somewhat cleared the ground by a statement of the difficulties before us, we shall proceed to the portraits themselves. It would be profitless and far too extensive a task to attempt to enumerate or describe all. It may be better to follow the plan adopted in the case of yaws (see page 177), and arrange them under certain propositions which it is desirable to illustrate.

PORTRAITS ILLUSTRATING THE EARLIEST STAGES OF LEPROSY.

In a large majority of cases leprosy patients do not come under observation until the disease is well advanced, and the pictorial representations of the initial symptoms of the disease are not numerous.



The maculae of Leprosy in an early stage. Only two patches are to be seen; both are well defined and somewhat irregular in shape with decoloration over their whole area especially marked at their borders. (From a photograph given by Dr. Arning.)

Our collection, however, possesses several.

In a photograph, taken from one of Dr. Arning's, are represented two somewhat irregular well-defined patches on the back of a coloured girl (Sandwich Islands). This is a very valuable and instructive portrait, since it exhibits appearances which are very common in the early stages of lepra. It is precisely for such patches as these that physicians in quest of leprosy in immigrants and others search. They have been long well known to Norwegian specialists. Not infrequently for several years a patient may exhibit no other indications of the malady than these isolated patches. In one of the patients, who has attended repeatedly at the Polyclinic consultations, the history given by the man is that for several years he had had nothing but a patch over one hip almost exactly in the position of the lower one shown in our illustration. It is very difficult in many cases to explain the precise relation of these white patches (which are always anæsthetic) to the brown discolouration of adjacent parts which often attends them. In some instances a brown patch is the first stage, in the middle of which at a later one the skin becomes white and devoid of sensation. In others, however, the whiteness is apparently the earliest change. Many of our portraits would suggest the probability that a condition of diffuse dusky erythema of the skin generally is an early stage, and that upon this the white patches are subsequently developed. This diffuse erythema, attended only by slight tumefaction, might easily be overlooked both by patient and physician, especially on a dark skin. It is only when the changes are retrogressive and the skin is becoming white that loss of sensation is observed. When once this retrogression has set in, its progress is remarkably like that of the disease known as leucoderma. The white areas enlarge and coalesce, and at length only irregular bands of brown are left. These changes in various stages of progress are well illustrated in the portrait of a man's thigh (No. 1) and of a boy's arm (No. 2), both of them original, and in several from other sources. The close resemblance of the decolorisation to that of leucoderma is well shown in three portraits taken from Dr. Hillis' work. These, with a number of others, illustrating the macular and erythematous conditions followed by leucodermic changes, are mounted together in one of the swing-frames.



Leprosy in the macular stage. Very numerous dusky slight elevated patches, many of which show white decoloration (with anæsthesia) in their centres. (From photograph by Dr. Arning.)

The dusky erythema of the skin which, either diffused or in isolated patches, is undoubtedly the most common of the early conditions in leprosy, may be attended in some cases, and especially in some regions, by definite tumefaction. On the face and hands this tumefaction may amount to solid œdema and become very conspicuous. When mapped out by furrows it produces appearances which may suggest the term "tubercle." A glance at any collection of so-called "tubercular leprosy" will convince the observer that this condition of pachydermatous solid œdema was all that was present. Indeed in one portrait taken from Dr. Impey's book (see swing-frame) and named by him "tubercular leprosy," the author with much candour asks his readers to "note the smooth condition of the skin and the absence of distinct tubercles." In another plate taken from the same source the state of transition between solid œdema and a "tubercular" condition is admirably illustrated. The man's arms are universally pachydermatous, and attention is asked to the flattened tubercles conforming to some extent to the flexures of the skin, and showing the island of the cutis.

It may be doubted whether conditions which can fairly be called tubercular are ever the first stage of leprosy or ever exist uncomplicated by others. Our collection comprises very many in which it is definitely stated that they were secondary to others, such as neuritis and maculæ, and not a single one in which there is good evidence that they were not so. We may therefore regard the tubercular state as for the most part an exaggeration of œdematous tumefaction which occurs in almost all and as usually occurring in a late stage. A vast number of portraits go to prove that on the face and hands almost alone occur the changes which receive this name. There are a few exceptions in which tubercles are said to have been present on the trunk, but in all these the tubercles on the trunk have been few in number and ill marked.

(To be continued.)

CORRESPONDENCE AND ANSWERS.

Re SPRUE.—The POLYCLINIC, No. 10, p. 255 (“Definition of Words and Terms). *Sprue* is from the Dutch *spruw* = (pathological) thrush. *Spreu*, &c., also used in Scotch for same thing.

Dr. Thin quite rightly gives the origin of the word in his interesting contribution to Psilosis (*linguæ et intestini*), vol. lxxv. of *Med. Chir. Transactions*, p. 285 (1892).—GEORGE PERNET.

* * *

“I HAVE always ranked Kaffraria as the finest part of South Africa, if not, indeed, the most fertile and lovely locality in the known world.”—Rev. F. Fleming in *Geographical Society's Transactions*.

* * *

IN *The Illustrated Sporting News* of January 15, 1895, the following statements occur: “The fish in Table Bay is very abundant. It is said that the docks of Cape Town Harbour are sometimes literally blocked with fish.”

“Pickled in the Dutch fashion Cape Town fish may occasionally be met with at farmers’ houses in the interior.”

* * *

MALTHUS.—For the present England is not over populated and we may safely leave to the future the discovery of more convenient checks on population than we at present possess. For the present our interest and duty is to facilitate communication with other parts of the world, and to make colonisation more easy and satisfactory.

* * *

GINSENG.—The Ginseng plant is rare. It is sought eagerly in the forests of Manchuria, and such is its repute with the Chinese that a single plant may be worth £15 (Younghusband), only the genuine wild plant is acceptable and the older the better. It is said that those who search for it observe a strict code of honour and that they will clear away the brush around a young undersized plant and leave it to grow, in full confidence that no one else will take it. The older the root the greater is its activity as a drug. Ginseng is a plant of the family *aradaciæ*, and has a forked tap root like that of the mandrake. The root is macerated, then dried, when it becomes almost resinous. It is preserved with great care wrapped in silk and the best is worth its weight in gold. Needless to say it is in its supposed power as an aphrodisiac that its value depends. Yet in China it is a customary and acceptable present from one friend to another. It has been extensively cultivated, but under cultivation assumes the habits of an annual and does not form a sufficiently active resin.

* * *

X.Y.—It is believed that the rate of increase of population in this country remains from year to year fairly constant. The birth rate, however, declines, and the result is attained by a compensatory reduction in the death-rate. Thus the average duration of life is somewhat increased. In England the birth-rate and death-rate stood at about 36 per 1,000 and 23 per 1,000 respectively in the year 1877, while they were reduced to about 29·7 per 1,000 and 19 per 1,000 in the year 1899.

DIARY FOR NOVEMBER.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m.

| | | |
|----|---------------|---|
| 1 | Thursday ... | Cons. (Surg.). Mr. Hutchinson. |
| 2 | Friday ... | Cons. (Eye). Mr. Holmes Spicer. |
| 3 | Saturday ... | |
| 4 | SUNDAY ... | |
| 5 | Monday ... | Cons. (Skin). Dr. J. J. Pringle. |
| 6 | Tuesday ... | Cons. (Med.). Dr. R. L. Bowles. |
| 7 | Wednesday ... | Clinical Lecture. Dr. Christopher Childs. |
| 8 | Thursday ... | Cons. (Surg.). Mr. Hutchinson. |
| 9 | Friday ... | Cons. (Throat). Dr. Herbert Tilley. |
| 10 | Saturday ... | |
| 11 | SUNDAY ... | |
| 12 | Monday ... | Cons. (Skin). Mr. Malcolm Morris. |
| 13 | Tuesday ... | Cons. (Med.). Dr. W. Ewart. |
| 14 | Wednesday ... | Clinical Lecture. Mr. W. H. A. Jacobson. |
| 15 | Thursday ... | Cons. (Surg.). Mr. Hutchinson. |
| 16 | Friday ... | Cons. (Ear). Dr. J. Dundas Grant. |
| 17 | Saturday ... | |
| 18 | SUNDAY ... | |
| 19 | Monday ... | Cons. (Skin). Dr. J. F. Payne. |
| 20 | Tuesday ... | Cons. (Med.). Dr. S. T. Sharkey. |
| 21 | Wednesday ... | Clinical Lecture. Mr. James Cantlie. |
| 22 | Thursday ... | Cons. (Surg.). Mr. Hutchinson. |
| 23 | Friday ... | Cons. (Eye). Mr. Holmes Spicer. |
| 24 | Saturday ... | |
| 25 | SUNDAY ... | |
| 26 | Monday ... | Cons. (Skin). Dr. Radcliffe Crocker. |
| 27 | Tuesday ... | Cons. (Med.). Dr. Seymour Taylor. |
| 28 | Wednesday ... | Cons. (Pædiatrics). Dr. W. B. Cheadle. |
| 29 | Thursday ... | Cons. (Surg.). Mr. Hutchinson. |
| 30 | Friday ... | Cons. (Throat). Dr. StClair Thomson. |

THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'
COLLEGE, LONDON.

VOL. III., No. 12.—DECEMBER, 1900.

OUR NEXT DINNER.

WE desire earnestly to secure the sympathetic and serious attention of all our members to our forthcoming Dinner. Perhaps it would be better named proximate than forthcoming, for it will probably not take place till May or June of next year. It is, however, of the utmost importance in such matters to begin well beforehand. The Council has had the matter on its mind ever since the last occasion, and a half promise to take the chair was obtained some months ago from one of our most distinguished public men, under whose presidency it would become an assured success. At its last meeting the Council appointed a small Committee to take charge of details. Mr. Malcolm Morris is its chairman and our excellent Dean its Secretary. We cannot too strongly urge upon all our members the duty of active co-operation. The object of the Dinner is, of course, to assist the finances of the College. It is in the matter of income that we are at present rather weak. In other respects we are prosperous. The attendance at our consultations and clinical lectures steadily increases, and is now as large as our rooms can comfortably accommodate. Our pathological laboratory is in constant use. Our museum is well filled, and a Companion-catalogue is in good progress. Our Journal appears regularly, and, in addition to being a record of our work, contains much which is, we hope, calculated to increase the knowledge of those who read it. The

clinical lectures delivered within our walls have been eagerly appropriated by the medical press. Arrangements are in satisfactory progress for the association with us of a considerable number of other institutions, so as to give to our members largely increased opportunities for hospital experience. Whilst, however, we may put in a modest claim to general prosperity, we are bound to admit that our expenditure exceeds our income and that we are somewhat in debt. A united and vigorous effort is required to change this state of things.

The efforts of all friends of the College are required in two directions. First, to obtain new members. A new member not only adds his quota to the yearly income, but what is yet more important, he extends in his own personality the usefulness of the institution. Secondly, to obtain donations to our funds. It is sometimes said that it is difficult to beg from the non-professional public for a medical institution which has no hospital and which cannot show a long roll of patients who have been relieved. This is true to the extent that it is only from the more intelligent and thoughtful section of the wealthy and benevolent that we can expect attention to our claims. To such, however, it can surely not be difficult to explain that we give consultation advice, if not to great numbers, at any rate to a class of cases in very special need of it, and that we save many from the necessity of hospital attendance and give them the advantages of hospital skill whilst enabling them to remain at home. Further, it may be urged most truthfully that we exercise a very wide influence on the interests of the sick poor by increasing the skill and knowledge of the practitioners who attend them. An institution which brings together on four afternoons of every week from fifty to eighty family practitioners for mutual instruction in consultation in difficult cases of disease must be contributing very largely to the general usefulness of the profession. In that usefulness the poor will be the first and greatest gainers.

Such are some of the arguments which our members may, we think, fairly urge when they seek donations to our funds from their wealthy friends. We beg of them to press them seriously in all suitable directions, and to feel that the future financial prosperity of our institution depends to a not inconsiderable extent upon their exertions.

APPENDICITIS.

IN the very interesting lecture which Mr. Jacobson delivered in our Theatre a week ago and which we print in full at page 320, he very wisely restricted himself to a single one of the several questions which concern the modern treatment of appendicitis. He dealt only with those cases in which symptoms more or less severe, or threatening to be severe, are present. Respecting them he asked—is it wise to attempt to subdue the local inflammation by other measures, or ought the operation to be at once performed? We may perhaps assume that professional opinion is well-nigh agreed on two points in reference to the treatment of appendicitis cases. If an acute case has advanced to the stage of abscess or to that of general peritonitis, in other words, if the patient's life is in immediate and considerable danger, then the operation must be done at once. It may easily fail to save life, but it will not add to the danger, and in not a few cases it affords the patient his one and only chance. In another class, that, namely, in which a patient has passed through one or more attacks and has recovered from them, but with persisting local irritation and recurring liability, it is wise to operate. Most would indeed say that if a patient has had one attack and got through it the best plan is to remove the appendix, since it is clearly a source of danger. Accepting, then, the position that an attack of appendicitis implies the necessity for the removal of the appendix, the only question that remains is when should it be done? It would appear that in skilful hands the operation done in the quiescent condition is almost devoid of risk. One operator, we believe, speaks of 160 cases without a death, and another of 600 with but one death. On the other hand, all admit that during acute inflammation there is risk, and very probably that risk is proportionate to the severity and duration of the attack. The severity is not by any means always in relation to the duration, for some cases are severe from the very first.

Mr. Jacobson speaks of two schools, one being that of those who think that during inflammation it is safer to wait, and the other that it is better to operate early. He ranges himself very decidedly in

the latter, and yet it must be admitted that at the conclusion of his lecture his trumpet gave a slightly uncertain sound; for he laid down rules for the non-operative treatment, as if it were still open to consideration.

The expression, "*acute* appendicitis," is possibly a little unfortunate, for only a small minority of cases of first attacks of appendicitis are severe or acute at their onset. Now, what is wanted is to find a rule of practice for the surgeon who is called in to see a patient during his first attack of pain in the right iliac region with a definite and tender swelling. Ought he at once to call in the operating surgeon, or should he try to subdue the symptoms in the old-fashioned way, by fomentations and opium? If he decides on the latter he may be successful, but it will be with the prospect of an operation ultimately, and possibly of other attacks in the interval. If, on the other hand, he is not successful, and the case passes on to local suppuration or to general peritonitis, then the operation will have to be done under unfavourable conditions.

What we seem to need in order to guide our judgments is more accurate data as to the precise amount of risk which attends the operation in very early stages of inflammation. Plenty of statements as regards these operations have been published, but for the most part they are not adequately classified. It may be that if we could get accurate facts as to the mortality in cases operated on very early, we should find that the present estimate of risk is higher than it need be. If it can be shown that the risk in experienced hands is trivial, then the earliest indications of trouble about the appendix may come to be regarded as a danger-flag which ought not to be disregarded for a day. It may be allowed to imply that the patient will sooner or later need the operation, and that the sooner it is done the sooner is safety secured. The possession of an appendix is a danger to us all, but it is an especial source of danger to all those who have experienced indications that theirs is not in a healthy state. They may escape further trouble—there are plenty of persons living who have had single attacks, and now appear perfectly well—but they are never safe. At any time another attack may occur, and life may be placed in jeopardy.

We recommended very strongly not long ago that medical men should use their influence with those of their patients who have

become parents to have all male infants circumcised. We referred at the same time to a movement in the Jewish community in favour of placing their religious rite in the hands of surgeons for its performance. Is it too much to hope that these two proposals will both be realised, and that all male children will, at some not very distant time, have the useless and dangerous prepuce removed on the eighth day by surgical hands, and that, at the same sitting, the appendix vermiformis may also be taken. It is, of course, to be understood that the latter half of this social rite should be extended also to female infants.

PAGET'S CANCER OF THE NIPPLE REGION.

It may now, we believe, be written with much confidence that Paget's disease of the nipple-region is from first to last a form of epithelial cancer and that it has nothing to do with eczema on the one hand or psorospermiosis on the other. In its early stages its new growth is very thin and its ulceration exceedingly superficial, and hence its resemblance to an eczematous excoriation. Coccideiform bodies are undoubtedly present, they are, however, not parasitic but modifications of the epithelial cell. This latter fact is almost openly conceded by Darier himself, to whose industrious researches in conjunction with those of Dr. Wickham we were indebted for having our attention drawn to their presence and peculiarities. Thus then the Nipple Cancer takes its place in the family which includes rodent ulcer and other less well recognised varieties of epithelioma of the skin. That forms of disease closely resembling it may be met with on other parts is well established. Radcliffe Crocker has published one such in detail, in which the scrotum was affected, and it has fallen to the lot of the writer to observe several others. They have usually been classed as varieties of rodent ulcer, but the name matters little. They all have these features in common—that the ulceration travels slowly over the skin presenting what is designated “the polycyclical border” but rarely passing deeply and never causing disease of the glands. The precise structure in the skin or mucous membrane in which the morbid process has its starting point may perhaps differ in different

cases, and hence may arise certain variations in the course of the disease which are observed in different cases. Some forms of rodent cancer of the face are exceedingly superficial through a long career and almost all are so in their early stages. At later stages the amount of new growth may be very greatly increased. It is the same with the nipple disease—sooner or later it may be attended by bulky epitheliomatous tumours in the breast itself.

In his latest communication on this subject Darier writes: "The epithelioma of Paget's disease has as its starting point either the glandular ducts of the nipple or the superficial epidermis. There is nothing special about its structure; 'pseudo-coccidia' are found in varying quantities in the epitheliomatous lobes, greatly resembling those in the superficial epidermis, but also comparable to those elements of the same sizes which, truth to tell, are contained in every epithelioma of the skin." This sentence may be held to amount, as we have suggested above, to an abandonment of the parasitic theory and to an admission of the pseudo character of the coccidia. It is a great satisfaction to have a controversy set at rest and to be permitted to place a form of disease which had been supposed to be *sui generis* in line with its natural relations. The disease may now be defined to be "the form which cancer of the skin assumes when it has its commencement on the surface of the nipple itself whether at its tip or base."

TIERRA DEL FUEGO.

TIERRA DEL FUEGO is a large irregularly-shaped island, which at first sight looks on the map as if it were the extremity of the American continent. It is in reality separated from the main land by the narrow and tortuous Straits of Magellan. It is in latitude 53° and 54° , on a level with South Georgia and a little south of the Falkland Isles. Patagonia and the Patagonians are on the mainland, and the straits separate them. Patagonia is inhabited by a race of reputed giants, but the native Fuegians are of small stature. Many Patagonians have, however, crossed the straits, and now possess the

north part of the island. There are a number of much smaller islands to the west and south of Tierra, and to the southern extremity of one of the latter the name of Cape Horn has been attached.

The original race had probably no affinities to the Patagonians, and is supposed to be more nearly related to the Indians of Chili. From time to time, however, Patagonians have crossed the straits, and a mixed population has resulted. The native Fuegians occupy, perhaps, the very lowest scale of culture in the American race, are savage in their habits, and not unsuspected of occasional cannibalism.

By some of the most modern geographers the name Tierra del Fuego is made to comprise all the Fuegian Archipelago, and to the large island above referred to the name of King Charles' South Land, Onas, or East Fuegia is given. It is to be understood, however, that this island is very much larger than all the rest put together. It would seem, therefore, that the attempt to change the name is scarcely a wise one, and that it might be better still to speak of "Tierra del Fuego and its Archipelago." The conditions of life on this large island—200 miles long—and that on the smaller ones are very different. The large island has large mammals, a species of llama, &c., and the American ostrich (the Rhea), whilst the smaller ones to south and west have only two foxes, a bat, a few rats and mice. It is, accordingly, clear that they have been detached from the mainland at very different epochs.

A great number of kitchen middens have been found on the coast, proving that the natives had for long been in the habit of eating the mollusca and such fish as they could catch. It is said that in some parts a large yellow mushroom, which grows near the roots of beech trees, constitutes an important article of food. No crops were formerly cultivated, but various roots and wild vegetables were eaten.

The native Fuegians, or Yahgans, are believed to represent an aboriginal race of extreme antiquity. They are in sole possession of the southern part of the island, that is north of Beagle Straits. It is to them almost exclusively that missionary enterprise has as yet been directed.

It is reported that the Fuegians, or at any rate some of them, show a distaste for alcohol in all forms. They are, however, very

fond of tobacco. Their Patagonian neighbours, on the contrary, take anything alcoholic that they can get. In the year 1886 there was published, in the *Cornhill Magazine*, "The story of the one pioneer of Tierra del Fuego." It was the narrative of the six months' experience of a sailor whose life had been preserved after a massacre of all his companions. He found a Chilian woman who, under similar circumstances, had been saved from death, living as the wife of one of the chiefs and the mother of a family. He saw her, however, but once. He was wrecked on the west coast, and describes the natives of that region as a small race of dark copper-coloured skin. They appeared to be almost insensible to cold, and although their climate was that of the north of Scotland, they displayed but little skill in building huts, and were content with very poor clothing. Their food on the coast consisted of clams and mussels eaten raw, and occasionally the flesh of seals. When hunting inland they often killed the guanaco, a species of llama. When they did so, they would fall to like so many wolves, tear the animal to pieces, and devour it raw.

Nothing is known as to the prevalence of leprosy or other maladies in the islands. It is believed that there is considerable mineral wealth and that coal is to be obtained. If such be the case, the island will no doubt before long become part of the civilised world, for a coaling station off Cape Horn would be very valuable.

CHANGE OF FAST-DAY DIET AT THE TIME OF THE REFORMATION.

ALL items of fact are of interest as regards the changes in diet which were taking place during the centuries which witnessed the decline of Leprosy in Europe.

When Sir Thomas Elyot, as the King's Envoy in 1532, was at Nuremberg, he records "we were well entertained, and that night the Senate sent to us thirty galons of wyne, twenty pikes, thirty carpes, a hundred dasis, with sundry confections." He adds, "Although fish was sent to us, yet universally and openly throughout the towne men did eat flessch." The Reformation was at this time in progress, and we are further told that all the "preestes hadd

wyves; and thei were the fayvrit women of the towne." The reason that fish was supplied to the Envoy was of course that it was a Catholic Fast which he was supposed to keep.

Leprosy in Europe and in the British Isles was at its height in the eleventh century. This was the age of Hildebrand and of the ascendancy of Roman Catholicism. It began to decline before the time of the Reformation, but was apparently much expedited in its disappearance by that event. It lingered longest in Catholic countries, indeed it still does so in some which are adjacent to others from which it has disappeared. It never followed the Greek Church the fasts of which exclude fish as well as flesh.

THE NATURE OF ALOPECIA AREATA.

IN reference to the nature of alopecia we are glad to observe that Lassar (of Berlin) holds that the nervous theory has lost ground more and more and that the parasitic one is the most probable, and that he is in the main supported in these conclusions by Dr. Norman Walker, of Edinburgh. Pavlof, of St. Petersburg, has made a contribution to international dermatology by stating that this form of alopecia is not so rare in Russia as has been supposed and that he has himself in ten years seen 150 cases. He has never observed contagion and is still inclined to the nervous theory. Sabouraud, of Paris, has made some statements which to English observers are very puzzling. He appears to think that the typical alopecia areata which begins on the occiput is most common in childhood and disappears at puberty, and that hereditary influence is definite. In England we know nothing of hereditary influence, and find the malady more common after than before puberty. The distinctions which this distinguished observer would attempt to draw between the Area Celsi and Bateman's alopecia are wholly unknown to us. Putting aside certain exceptional and rare cases, we hold that the alopecia areata which we occasionally see before puberty and that which we see so frequently after it are one and the same disease. Dr. Sabouraud should publish a portrait of what he means by "Area Celsi" and give details of some illustrative cases.

SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

SOME REMARKS ON THE QUESTION OF EARLY OPERATION IN ACUTE APPENDICITIS.

BY W. H. A. JACOBSON, M.CH.OXON.

Surgeon to Guy's Hospital.

GENTLEMEN,—I have chosen for the subject of my clinical lecture “Some Remarks on the Question of Early Operation in Acute Appendicitis,” for the following reasons:—Acute appendicitis is a common disease; it attacks all ranks of life; it is a disease of which the mortality is, to all thoughtful surgeons, far too high. Again, there will be no denying the fact that acute appendicitis is a disease of which, though it may begin mildly and favourably, no one can foretell the outcome. Finally, it appears certain that, of late years, while the frequency of acute appendicitis has increased the severity has certainly not diminished. I am aware that this is disputed by those who maintain that acute appendicitis was equally common twenty or thirty years ago, but that it was not diagnosed. I reject this view absolutely. From a theoretical point of view, and speaking of my own hospital only, I am not going to believe that the physicians of Guy's Hospital would have overlooked a disease with such well-marked features had it been equally common in those days in the wards, or that three of them, whose knowledge of pathology and morbid anatomy was unequalled—Sir S. Wilks, Dr. Moxon, and Dr. Fagge—would have overlooked, on the necropsy-table, ulceration, sloughing, and gangrene of the appendix as a cause of suppurative peritonitis, had the disease been as common and as fatal then as it is now. But to turn to facts. Statistics are often to be mistrusted; the ones I place before you I believe to be reliable. They speak for themselves.

Dr. Cleveland, medical registrar at Guy's Hospital, and two of

my dressers, Mr. Trail and Mr. Grey, have been good enough to collect the cases of appendicitis which have been admitted into Guy's Hospital during the years 1889 to 1899 inclusive, and those in which acute peritonitis occurred. You will see that the numbers admitted have risen from thirteen to 101, and the cases in which acute peritonitis occurred have diminished very little, in spite of improved treatment. Thus in the ten years, from 1889 to 1898, the deaths from acute peritonitis have only diminished from 2 in 17, or 1 in 8, to 9 in 101, or 1 in 11.

In New York the increase seems to have been even more marked. I have only time to quote the statistics of one hospital. Dr. Wiener, in a most candid and helpful paper (*N. Y. Med. Rec.*, May 19, 1900), gives the following statistics from the Mount Sinai Hospital:—

| Years. | 1894 | 1895 | 1896 | 1897 | 1898 |
|---|------|------|------|------|-----------|
| Total of Appendicitis cases | 41 | 87 | 91 | 130 | 149 = 498 |
| Cases in which General Peritonitis occurred | 7 | 10 | 14 | 23 | 22 = 76 |

You will see that there is the same marked agreement in the records of the hospitals, American and English, as to the frequency of acute peritonitis. In the American it occurred in about 1 of every 6 cases, or in 76 out of 458 cases; in the English one, it was 1 in 7, or 65 out of 476 cases. And I would ask you to note that in the last year of the mortality, 1898, it is still about the same: 14 out of 101, or 1 in 7.

I purpose first to bring before you certain practical points in the structure and contents of the appendix which I think every one of us should bear in mind in every case of appendicitis which we see, and the bearing of these practical points on the infection of the appendix in acute appendicitis; for unless we bear in mind that in every case of appendicitis, however mild, the appendix is, to a certain extent, infected, we shall fail to understand the gravity of the disease, its not infrequent treachery, and to grasp those urgent clinical features which indicate the need of early operation.

Structure of Appendix.

To begin with, and speaking generally, this organ is vestigial, and therefore, like other vestigial structures which have ceased to be necessary or useful, its vitality is poor, and it is degenerating.

Like other vestigial structures, it has been well described (Bland Sutton) as a pensioner, but a pensioner which, from its feeble structure, its poor vitality, and, above all, from its important associations, is a very dangerous one.

To take the chief practical points connected with each coat.

I. and II.—*Mucous and Submucous.*

Here microbes of grave importance, even in health, are to be noted as constantly present, and in contact with the lining of the appendix of every one of us. The bacillus coli communis is constantly present. Dr. Hodenpyl, of New York, one of the first to publish the results of study of the bacteriology of the appendix, found in one case a few colonies of the streptococcus pyogenes. Mr. Lockwood, whose name is well known as an authority, proved that both streptococci and staphylococci might be present, and the mucosa superficially ulcerated, thus affording an atrium for infection, in a case in which the symptoms for eighteen months had only been severe enough to justify a diagnosis of appendicular colic. In two cases of appendicitis, one with four and the other with six attacks, streptococci were found in the appendix when removed.

As long as the appendix is healthy, as long as the diet is wise and the bowels act regularly, these microbes are carried out of the appendix just as regularly as colonies of the same bacillus are daily swept out of the colon. But the bacillus coli communis, while inert in the intestine under normal conditions, when its normal surroundings, viz., normal peristalsis, naturally scanty mucus, and faecal matter, are altered, or when it gets into tissues to which it does not properly belong, it becomes pathogenic. The appendix is no exception to the general rule. To take one other instance only. As long as our urethras are healthy, and daily often flushed out, hosts of microbes are carried over the surface, some of which sink in the numerous recesses of the mucous membrane and gland orifices. Under normal conditions they remain inert for years, perhaps a lifetime, but if an infection-atrium is afforded by a lesion, however slight, from the passage of a catheter, we are all familiar with the urethritis, the painful, septic epididymo-orchitis, and the cystitis which may follow.

Note also the single layer of columnar epithelium, the only barrier between the bacilli constantly present in its lumen and the structure of the appendix, and one so readily injured and at once affording an infection-atrrium.

Next, the large amount of lymphoid tissue, the submucosa being almost wholly occupied by nodules of this tissue. The resemblance, in the abundance of this lymphoid tissue, between this organ and the tonsil, and the fact that the appendix has, on this account, been called "the abdominal tonsil," is familiar to you all. The explanation of the abundance of lymphoid tissue in the two places is probably this. In each case the object of the lymphoid tissue is to act as a filter for, and a consumer of, bacteria. We all know how much these—filtration and destruction of bacteria—are needed in the mouth; and I may remind you that in the pig, the dirtiest of feeders, there is a large, thick collar of lymphoid tissue all round the upper neck. This tissue is richly present in the appendix as part of the cæcum, where its abundance is probably intended to meet the delay in the fæces which may take place in this part of the colon. We all know how frequently the lymphoid tissue of the oral tonsil becomes infected, and how it swells, sometimes meeting its fellow across the middle line. But, here, it has the pharynx to project into. With the lymphoid tissue of the appendix it is a very different matter, as it is confined within the narrow limits of the muscular and peritoneal tube.

III.—*Muscular Coats.*

The chief point of practical importance here is one to which Mr. Lockwood has recently drawn attention, viz., that there are numerous gaps between the fibres of the muscular coats of this degenerating organ, by which the submucous and subperitoneal coats become directly continuous. These gaps obviously supply paths by which infection can pass, easily and quickly, from the mucous to the peritoneal surface.

IV.—*Peritoneal Coat.*

The most important point here is the mesentery of the appendix. In proof of the appendix being a degenerating organ, we sometimes find the mesentery absent, so that the appendix is quite free in the

peritoneal sac. Here, if infection run high and gangrene or perforation occur, the formation of life-saving adhesions is not likely. More often the mesentery, though present, is too short, reaching only half or two-thirds along the appendix, and curling or kinking it. This condition, when present—and we can never tell when it is present—obviously renders gangrene very likely on the distal side of the too short mesentery by shutting off the blood supply through the artery of the appendix, an artery which, you will remember, is single without any collateral circulation, and thus strongly contrasted with the other arteries along the whole length of the digestive tract.

I pass from the *structure* to practical points in the *contents* of the appendix.

(a) *Fæcal Matter.*

In a normal appendix this should be slight in amount, and of about the same consistency as that in the cæcum. It should be removed regularly.

Contrast the above conditions with those present in the appendix of the subject of habitual constipation. The fæcal matter, no longer small in amount and regularly removed, forms one of those concretions so often met with and so familiar to every operating surgeon *outside* the appendix and free amongst the adjacent coils of intestine, when he explores in a too late operation. What has been the effect of such a concretion earlier in their history of the case? Though soft enough to crumble between the finger and thumb, they are strong enough to work grave mischief in a degenerating structure like the appendix. They block its canal, preventing the escape of mucus, and, far worse, by their gradual increase and pressure, they abrade the delicate single layer of epithelium, and so produce an infection-atrium for bacilli. Lastly, Mr. Lockwood has shown that these fæcal concretions are, when recent, masses of bacilli.

(b) *Mucus and Bacilli.*

Under normal conditions the mucus is slight in amount, and though not sterile, the microbes it contains, especially the bacilli coli communis, are in a state of inactivity. But let us recall for a

moment the result of an unwise meal ; I will instance only one—a boy of 6 allowed to eat freely of pine-apple at the midday-meal, followed, at six, by lobster and cheese. It is easy to picture the violent fermentation, the active peristalsis, the increased mucus, which such poisonous stuff would set up as it was swept along the ilium into the cæcum and so into the appendix, itself perhaps damaged or tied down by previous attacks. The excitement of any colonies of bacilli coli communis which up to this time have been resting inactive in the appendix, and the grave peril in which the patient is placed, especially if any abrasions of his appendix epithelium exist, are obvious.

In brief, the appendix must always be looked upon (like the middle ear) as a test-tube containing dangerous organisms and culture-media which only await a change in their surroundings, and an infection-atrium, to start an acute appendicitis.

VARIETIES OF ACUTE APPENDICITIS, AND THEIR RELATION TO THE ABOVE POINTS.

I.—*Catarrhal Appendicitis.*

Mild appendicitis. This variety has a strong tendency to recover, and as a large proportion is successfully treated by medicine, it has been called by some “medical appendicitis.” But note that in this catarrhal form the epithelium—a single layer, you will remember—is shed, and therefore a possible infection-atrium is always present, and it depends entirely on how far the catarrhal change goes on towards fermentation in the mucus in the appendix, how far the activity of the bacilli coli communis is aroused, and how far the deeper tissues of the appendix are of good resisting vitality, it is in these points that it depends whether a merely catarrhal appendicitis shall extend from the lumen into the tissues of the organ. Note also that streptococci may be present even in the catarrhal form. To put it briefly, a catarrhal appendicitis is potentially an infective one, and cannot be classed absolutely by itself, and when classed by itself and spoken lightly of, the above provisos must be remembered. Dr. Morriss (“Lectures on Appendicitis,” New York) speaks thus strongly on this variety of catarrhal appendicitis: “I believe it to be usually wrong for us to make the diagnosis of catarrhal appendicitis at the bedside before the specimen has been seen.”

II.—*Ulcerative Appendicitis.*

In this form not only is the epithelium shed, but the mucous and submucous coats are opened into. The process, if it halt here, does so because the microbes are few in number, because the mucus which is their food is small in amount, and because the tissues into which the bacilli have now made their way are healthy and with good vitality, or to speak more precisely, because phagocytosis is active, and filtration or destruction of the microbes is prompt.

Perhaps, as in Dr. Morriss's terse and expressive words, the bacteria being few in number and "confined in a small space, commit suicide with their own toxins, just as saccaromycetes commit suicide with their own alcohol in vinous fermentation."

But note that though the patient recover, he is likely to carry about with him a damaged appendix with a mucous membrane scarred and of weakened resistance, the lumen perhaps strictured at one or two spots, with, possibly, a cystic dilatation containing mucus, perhaps sterile from the death of the microbes, but ready, at any time, to form a culture-medium if these swarm into activity again.

III.—*Appendicitis (with or without Perforation) and Abscess.*

Here we may have (a) an abscess pointing through the abdominal wall; (b) an abscess in the peritoneal sac, more or less firmly walled in; (c) an abscess extra-peritoneal, usually lying to the right side and tending to creep upwards into the right lumbar region; (d) several localised collections of pus may exist at the same time.

IV.—*Appendicitis with Localised Adhesive Peritonitis.*

This form, like the catarrhal, often ends in recovery. But it often leads later to recurrent attacks from matting of the appendix in adhesions, a kinking of it, or adhesions between it and adjacent small intestine, interfering with normal regular peristalsis.

V.—*Fulminating Appendicitis, often Gangrenous.*

Here the infective process runs very high from first to last. The appendix sloughs either in one or more places, or *in toto*, partly from the destruction of its tissues owing to the very rapid production of

toxines by the swarming microbes, partly by closure of the capillaries, by thrombosis of the veins, and perhaps by shutting off of the arterial blood supply, though, as in the specimens which I have seen, the gangrene was moist, I think the veins were the vessels chiefly interfered with.

By some, fulminating and gangrenous appendicitis are spoken of as synonymous. This is not correct. By fulminating appendicitis, I mean an appendicitis running an acute course from first to last; it may be gangrenous, or it may not. But gangrene of the appendix may arise in a case which, for some days, has run a mild course, and in which microbe infectivity, having been for a time of a mild type, has awakened and run high.

VI.—*Recurrent Appendicitis.*

Owing to the shortness of the time I must limit my remarks entirely to cases of acute appendicitis.

QUESTION OF OPERATION IN ACUTE APPENDICITIS, WHEN TO OPERATE AND WHEN TO WAIT. TWO CAMPS OF OPINION.

(a) *Advocates of Waiting and Watching.*

Those who follow on these lines rely on the fact that the majority of cases of appendicitis recover under medical treatment. In other words, they represent that the dangerous forms in which sloughing or gangrene or perforation of the appendix with suppurative peritonitis, pylephlebitis, &c., follow are but few. Dr. Hawkins, quite one of the highest authorities on the subject, puts the death rate of appendicitis at 14 per cent., and hopes it may be reduced to 12 per cent.

With all respect to Dr. Hawkins, I, myself, look upon the above estimate of 14 per cent. as too low, when hospital cases are considered. It is interesting to note that Dr. MacDougall, in his address at Carlisle in 1896, quoting from returns made from the Edinburgh Royal Infirmary for the three years, 1893, 1894, and 1895, found that the death-rate of acute appendicitis was 25 per cent., and that the returns of two London hospitals—St. Bartholomew's, 1893 to 1895, and St. Thomas's, 1892 to 1894—gave a death-rate of nearly

20 per cent., and it is doubtful if these returns included all the cases admitted of purulent peritonitis. With regard to his more hopeful outlook, I have only to repeat what I have said as to the frequency of acute septic peritonitis. In the American and English hospitals the mortality of 1 in 6, and 1 in 7, respectively; further, in 1898, the last year of the records, the mortality was still 1 in 6, and 1 in 7.

The advocates of waiting and watching further maintain that in the indiscriminating removal of appendices which they say has been going on in America, we have had an abuse of surgery similar to that which characterised, some years ago, the operation of oöphorectomy.

(b) The Advocates of Operation at Once, or at the end of Thirty-six or Forty-eight Hours.

Let us consider how this school to which, I confess, I have felt myself drawn increasingly during the last few years, would answer the objections to early operation which I have just mentioned. And I will take the last first, viz., the criticism that this operation of early removal of the appendix has been abused, and the comparison between it and the similar abuse with which most of us are familiar as to oöphorectomy.

There is an old saying that "*Abusus non tollit usum.*" A pendulum of opinion which sways strongly first in one direction, then in another, needs watching. And in my opinion there is a danger that in being influenced by the needless operations which have no doubt been done in America and elsewhere, we shall lose sight of the very sound and splendid work done by the best surgeons of that country. I shall allude to this more in detail shortly. I will only add that in this country hasty and needless operating will certainly not be the rule of treatment, but there is a risk that in priding ourselves on this, we err on the other side. I am certain that the results of the best American surgeons are far superior to anything in this country, and are but little known amongst us.

With regard to the comparison between removal of the appendix, and the ovary, I scarcely think this holds good. A diseased ovary

may cripple, but it very rarely kills; it is not a vestigial structure; though unsound, it is not necessarily functionless; an appendix has not, like the ovary, peculiar importance not only to its owner, but also perhaps to others, an importance quite *sui generis*. The advocates of early operation would answer to the conservative school: "You sanction, nay, perhaps, you urge operation as soon as evidence of gangrene, perforation, suppurative peritonitis, or local abscess is certain. But by the time the evidence is sufficient for you to call in surgery, it is often too late: you admit that it is usually impossible to diagnose such conditions as gangrene and perforation till the disaster is announced by evidence which is unmistakable, but which announces a condition in which surgical interference is too often useless."

The advocates of early operation claim that by operating early, and thus making sure that infection has not extended beyond the peritoneum, the surgical death-rate would be much below the medical one, which we have seen to be put by one of the best authorities at 14 per cent. Thus Dr. Morriss holds that the death rate should not exceed 4 or 5 per cent. when cases of gangrene, perforation, and suppurative peritonitis are operated on, and goes so far as to say that a surgical death rate of 2 per cent. in cases operated on early "would be illegitimate."

Let us examine this claim that the medical death-rate will be much lowered by early surgical interference. It will be seen to stand or fall very largely upon the meaning of the word "early." The question at once arises, "How many cases are really seen within the first twenty-four or thirty-six hours?" Certainly, I think but few in hospital practice. Here the patient very often goes on working for days after he has had warnings of pain, and even sometimes with a lump in his right iliac fossa. We must face the fact that it will be difficult to determine whether, with this word "early" before us, we really are dealing with the first twenty-four or thirty-six hours. A patient, from carelessness or inaccuracy, or a desire to make the best of his case, from a dread of operation, may misrepresent his symptoms as just beginning. In reality this man had had, for a day or two, pain or other evidence that a catarrhal condition has been established, and thus the appendix epithelium has had time to become shed and an infection-atrrium has had the opportu-

nity of forming before a medical man is asked to see the patient. Then, when the latter is called in, the P.T. pain, tenderness, and so forth betoken not the commencement of an attack as the patient represents, but a stage in which an actual abrasion is present, perhaps even that the peritoneum is becoming infected.

Having mentioned this caution, we will suppose, for the sake of argument, that all cases are seen within a really early stage, viz., twenty-four hours. Is it certain that early operation at this stage will be largely successful? Let us examine the ground on which we stand. If we accept Dr. Hawkins' mortality of appendicitis treated medically as one of 14 per cent. from gangrene, perforation of the appendix, and suppurative peritonitis, in order to ensure a surgical mortality of 4 or 2 per cent.—though Dr. Morriss is inclined to look upon even the latter as “illegitimate”—it is clear that we must operate successfully on ninety-six or ninety-eight cases of acute appendicitis in the early stage. This is a statement which there is no gainsaying, and it is one which at once makes a mind capable of weighing evidence very thoughtful. When one considers the conditions under which this early operation may have to be done, in a febrile patient with an infected, septic organ to be removed, with intestines very likely distended, and many other conditions present the very reverse of those which make an operation during the quiescent stage so successful, it is difficult to say how far the medical mortality of 14 per cent., or, perhaps more correctly, of 20 per cent., will be reduced, even if the surgery be always that of skilled hands. That it will be reduced by habitual earlier operation, and in the lifetime of some of us, I am certain; but I doubt if it will be brought below 8 per cent., when all the conditions which surround the operation are duly weighed.

But, here, it will be only just to examine some of the results gained by the best of those American surgeons who advocate early operation in every case. These results are not sufficiently known in this country.

As time presses, I will take only two of the more recent ones, viz., those of Dr. Mynter, of Niagara, and Dr. Morriss, of New York. Dr. Mynter (“Appendicitis,” p. 172), whose book emphatically bears the stamp of a candid and judicious worker, writing in 1897, had had thirteen cases, all of which had more or less total gangrene

but yet without perforation. They *all* recovered by prompt operation and extirpation of the appendix. Two cases were operated on during the first day, five on the second day, two on the third day, three on the fourth day, and one on the seventh day. "These cases," he goes on to say, "are most interesting, as giving conclusive evidence of the importance of operating before perforation has occurred. No one can doubt that perforation with profuse peritonitis would shortly have occurred, and that they all would have died under any other than surgical treatment."

Dr. Mynter operated on another group of twenty cases, all of which had gangrene with perforation of the appendix, and commencing or diffuse peritonitis. Five of these recovered, while fifteen died—thirteen of diffuse peritonitis, one of gangrene of the cæcum, and one of suppurating pylephlebitis after the peritonitis had disappeared. The five who recovered were operated on, in two cases on the first day, in two cases on the second day, and in one case on the third day. Of the fifteen who died, one was operated on during the second day, two on the third day, five on the fourth day, two on the fifth day, four on the sixth day, and one on the seventh day.

Dr. Mynter adds: "Comment seems unnecessary; all died if operated on later than the third day."

Dr. Morriss's cases ("Lectures on Appendicitis," New York, 1895) are somewhat less carefully tabulated, but are most instructive.

Of ninety-one cases of acute appendicitis *operated on early, in fifty-nine in which only the immediate vicinity of the appendix was infected, although many of these cases involved extensive operative work, there was no death in this series of fifty-nine cases.*

In six cases of intense general septic peritonitis, with the whole abdominal cavity bathed in pus, *only one patient died.*

In three cases with intense general septic peritonitis, not marked by the presence of pus, *only one died.*

In twenty-three cases of the walled-off abscess form of appendicitis, the most varied complications were present. Five only of these died, but one of these deaths was from acute suppurative nephritis, a second from "intestinal obstruction due to adhesions which could not be separated at the time of operation on account of the patient's condition," and a third, already weak from several months' septic-

æmia due to an abscess overlooked before Dr. Morriss saw the case, died of a continuance of the septicæmia.

This death-rate of seven in ninety-one cases testifies in no uncertain terms of the admirable care and skill which must have been exercised to attain such a result.

Dr. Morriss is quite justified, after such success, in writing: "I feel that the death rate in 100 such cases as the list contains should not be more than 4 or 5 per cent., notwithstanding the fact that many of the cases were in a condition which seemed to prohibit interference."

It seems to me that even if this surgical death-rate of 4 or 5 per cent. were doubled, viz., 8 or 10 per cent., it would give a better result than the medical one of 14 or 20 per cent., and our duty would be clear.

But the following cautions must be borne in mind:—

First, that we have here the results of especial experience of those who have had opportunities of acquiring especial skill. Dr. Mynter strikes a very important note when he emphasizes the point that wherever the home surroundings are unfavourable the well-regulated operating room of a home or hospital is a *sine quâ non*.

Secondly, it is never to be forgotten that these operations are always serious, often very difficult, and that they require good experience, efficient assistance, and efficient antiseptic precautions.

Thirdly, in estimating the surgical death-rate, which I do not myself expect to be less than 6 or 8 per cent., when all the conditions under which this operation will be performed are taken into account, we must remember that in certain cases of appendicitis beginning very acutely, the operation, however early, will not save life. I refer to cases where a general peritonitis sets in early, possibly within the first few hours of the case coming under notice. The explanation of these cases probably is that in some it is not really a first attack. The history given is unreliable, the appendix is already a damaged one, and either gangrene or a perforation of its unhealthy structures sets in quickly, with the result of a rapid general peritonitis. In others the explanation is that the bacillary activity is, from the first, acute, the resisting power of the patient's tissues very poor, or that some minute point in the anatomy of the appendix, as the gaps between the fibres of the muscular roots (*vide supra*), facili-

tates rapid transit of the septic process. No one can tell how often the lives of our patients hang on such minute points.

There is another of the points of dispute between the two camps to which I would ask your attention. The advocates of early operation maintain that many of the cures which are secured by medical treatment—we will call them 80 or 85 per cent.—are not permanent and complete cures when followed up; but that permanent mischief is left behind, sometimes slight, sometimes severe and dangerous, and that patients would be saved from the great annoyance and suffering of recurrent attacks and much waste of time if the appendix were removed in the first attack. The following is an interesting instance of how incomplete may be the cure of a case treated on medical lines, and of the thread on which such a patient's life may be hanging:—

A gentleman, aged 23, was sent to me in July, 1896, by Dr. Goodhart with the following history:—In 1895 he had had a severe attack of appendicitis, in which the temperature was for some days between 102° or 103°. Under medical treatment he made an apparently perfect recovery. In June, 1896, while bowling for an eleven of the Zingari at Manchester, as he shot up to the crease he suddenly felt an acute pain and dropped to the ground. He was carried to an hotel in a state of collapse, and when the mischief had abated came into my hands, as I have said. There was the characteristic thickened knotty lump and tenderness at one small spot in the right iliac fossa. The appendix, when removed, showed a good deal of thickening in its distal half, but, save for the adhesion of one single tag of omentum at one spot, it struck me as being strangely free from adhesions, considering the severity of the two attacks. The patient made a good recovery, and is now planting and exporting that excellent dry sherry, “Pando,” at Xeres. I happened, after the operation, to pass a probe down the lumen of the appendix, when, to my surprise, the blunt end passed, without the slightest force, through the walls at a spot exactly where the tag of omentum was adherent. Here the end of the probe could be seen just covered by a filmy layer of peritoneum only. The chief events of the illness and the very narrow escape of the patient stood out very clearly. In the first severe attack, with a temperature of 103°, the appendix had suffered very severely; no walling-off life-saving

adhesions had formed, save the one, single and omental. As the patient was bowling his very best, the uplifted arm and rotation of the whole trunk upon one leg brought, by means of the latissimus dorsi, pectoralis major, and external oblique—all continuous with each other and with the muscles of the lower limb at Poupart's ligament—a violent strain upon the abdominal wall and so upon the omental tag, causing a stretching here, and, perhaps, a minute tear, and thus the agonising pain and collapse which heralded the onset of the second attack.

There is one other of the points of dispute between the two schools to which, as a surgeon, I must allude. By the opponents of routine early operation it has been objected that such a course would be followed by a large number of ventral hernias. There is, no doubt, truth in this, for the incision will, in many cases, have to be free in order to find the appendix and to enable the surgeon to get his field of operation thoroughly isolated with gauze tampons; secondly, drainage will often be required.

But a ventral hernia must weigh lightly against a saved life. To put this matter succinctly, it will be better for such a patient to be fitted with an abdominal belt than to be measured for his coffin.

I think it is for us in England to try and emulate the above results, such as those of Dr. Morriss, in which the mortality of very severe cases of acute appendicitis was reduced by skilful operation to 7 in 91; and I am sure very much can be done by you who are general practitioners by a wise treatment of these cases and by an earlier resort to surgery if, by the end of 36 or 48 hours, the mischief cannot honestly be said to be retrogressing.

May I be excused if I, who am only a surgeon, venture to recall to you the lines on which a case of acute appendicitis should be treated by those of us who are really alive to the perils of the disease and to the changes which may be going on in the appendix. Absolute rest, with an outside splint if the patient be restless, very little beyond boiled water or barley water for thirst, very little milk as productive of constipation, veal tea, mutton broth and the like, with champagne or sound spirit for sustenance; locally, an ice bag or hot creolin fomentation, whichever soothes the pain best; no poultices, as heavy and septic; really hot creolin fomentations soothing the pains and cleansing the skin if any operation be likely to be

required. Leeches, ointment of belladonna and the like are, I think, of little use and are much in the way if an operation is probable. No more opium is to be given than is absolutely needed. I know how easy it is to stand here and say this. I am not unmindful of the needs and difficulties of the general practitioner, on whom the brunt of the case falls and who is expected to do something promptly or someone else will be called in; but, on the other hand, I am certain that opium is often given both needlessly and harmfully. It is true it allays pain, checks peristalsis and produces sleep; but there is another side to the shield. By checking peristalsis it produces flatulence and causes the question to arise, is this only the flatulence of the opium or is it the commencing tympanites of peritonitis? By checking peristalsis it allays colicky griping, but, at the same time, it causes the retention of fluids necessarily septic and thus favours the absorption of toxins; further by removing pain it tends to mask one of the best symptoms that we have for our guidance and to screen one of the chief signals which the disease is hanging out. I, myself, look upon that pain in acute appendicitis which is not relieved by an ice bag or by hot fomentations, as, in itself, and as far as it goes, an indication of the probable need of operation. As to the use of aperients, what I may call the magnesia sulphate treatment, much as this is to be desired in cases where the bowels are loaded, or where, as is often the case, the acute attack has been brought on by the sudden fermentation and the turbulent peristalsis of an unwise meal, I think that, on the whole, it is wise not to employ them, and I base this opinion on the grounds already given that it is impossible to estimate correctly the condition of the appendix, and that grave mischief may be present without grave symptoms. The pulse and temperature should be noted by reliable hands every 3 or 4 hours, and the patient should be seen and examined at least three times in the 24 hours. If grave symptoms are still present at the end of 36 hours, McBurney's advice should be followed and an operation performed.

I will finish with a few remarks on these grave symptoms and their bearing upon the need of operation.

First as to the *Pulse and Temperature*. The higher they both are at the beginning the more probable is the occurrence of abscess, gangrene or perforation. A tendency of the pulse to increase is

ominous. In Meyer's words "If the pulse, with all the symptoms well developed, has a tendency to go above 116 or 118, still more, if it goes up to 120 *and stays there*, we should operate at once." In addition to the *frequency*, there is the *character* of the pulse. A small, weak and compressible pulse, especially if it be irregular, is much graver than a more rapid pulse which, while rapid, is regular and of good volume. Such a pulse is evidence of toxæmia and points to perforation and general peritonitis.

With regard to the temperature, this should show signs of falling within 36 hours. If it continues up it may point to the formation of pus; but all are agreed that the temperature is not of much importance in judging of the severity of an attack of acute appendicitis. The pulse is of far greater importance. According to Dr. Morriss (*loc. supr. cit.*), an appendix that is walled in may be completely destroyed without producing much change of the temperature or pulse. Dr. Mynter calls attention to the following very important point:—"A pulse considerably higher than the temperature (*e.g.*, a pulse of 130 and a temperature of 100) shows, in my experience, that perforation has occurred and that diffuse septic peritonitis is present." The pulse to which Mr. Barling (Ingleby Lectures, 1895) gave the name of the "paradox pulse," viz., a rising pulse and a falling temperature, is a rarer condition, but even more ominous of toxæmia, probably from perforation.

Another instance of the value of temperature is when having been low for the first few days it begins to rise steadily, or if after being high at first it has fallen and then again begins to rise. If such changes occur the temperature is of value, just as in the after-treatment of surgical cases anywhere else, and points to the presence of pus.

Pain and tenderness.—Persistence and increase of one or both of these are the chief points which indicate the need of operative interference. Sudden, acute increase in the pain points to perforation of the appendix, though this may take place without any such evidence. For my own part, pain that does not yield in thirty-six hours to the treatment which I have sketched above, pain that is not relieved by heat or ice-bag, pain that makes a medical man inclined to give opium freely, each and all of these are, to my mind, *per se*, indications of the need of operation. In estimating the

amount of pain, and, especially, its persistence, two cautions must be remembered. One, the amount of opium given must always be taken into account as masking pain and dulling the sensorium. The other is that a condition of sepsis present may blunt the feeling of pain.

Swelling.—This is of little value in acute cases during the first thirty-six hours as a guide to the need of operative interference. It may be absent though an appendix is on the point of sloughing, if such an appendix is devoid of any protective adhesions. It will be absent if the appendix lie mainly in the pelvis. It will be difficult to make out if the amount of inflammatory effusion is small, and if the appendix is retro-cæcal. On the other hand, a considerable degree of apparent inflammatory swelling may be simulated by the following combination. Omentum adherent to the inner aspect of Poupart's ligament, and, behind this, a coil of small intestine with plentiful adhesions lying in front of the cæcum and appendix.

Mistakes are, I think, usually made (1) by forgetting that in acute appendicitis, as in other diseases, there is a risk of our expecting each case to be typical, and that all the symptoms and signs will be present if grave complications are going to set in. Instead of waiting for most of or all the evidence to be before us, we ought more to estimate the value of what we have, and, especially, to note not so much what signs and symptoms are present, but—are those which *are* present progressing or regressing, increasing or diminishing?

One hears sometimes, especially when called in too late, the practitioner, when he sees the mischief present, excuse himself by saying that there were no urgent symptoms. Now while one of the chief dangers of acute appendicitis is that grave mischief *may* take place without grave symptoms, it is very rare, I think, that there is absolutely no evidence of impending mischief, no danger-signal whatever displayed. The onset of grave symptoms may have been insidious, but frequent watching and careful examination—the patient not being merely seen morning and evening—would have given at least a hint, perhaps one or two, that the progress of the case was not in the desired direction. As I have said, some of the evidence, most to be relied upon, may not have given help—thus, the temperature may have been quiet, and even the pulse also, while

a perforation was actually taking place. But, in such cases, there is usually one or more smaller points—and in my experience they do not usually come alone—to aid a frequent and careful observer. Thus, when the pulse and temperature are not helpful in a case where grave mischief is present in the appendix, we shall probably find other evidence of a toxæmic condition. During the last few hours the pulse, though not rapid, will have become more feeble, the patient will have become more apathetic and indifferent to food, his tongue will be drier and browner, he will have lost strength, while tenderness and rigidity, though not well defined, will, to careful eyes, be found to be more widely spread.

While speaking of those indications in acute appendicitis which call for early operation, I am sure that age is an important feature. I am strongly of opinion that an operation is *ceteris paribus* more called for in children. Owing to the small size of the parts, the limited incision, the restricted field for working in, operation, save in the case of an abscess coming forward through the abdominal wall, is here always more difficult. And the amount to be done and the difficulty of doing it does not grow less by waiting in these cases of acute appendicitis. Moreover, when such changes as gangrene and suppurative peritonitis are impending, the process here runs an acuter course. Moreover, sepsis is, in these weak folk, more quickly fatal from cardiac failure. Lastly, in children, we can get no reliable history to guide us.

With one more indication for operation I have done. Just as in cases of acute doubtful intra-abdominal inflammation, the rule is "Think of the appendix," so it should be the rule in acute appendicitis, as in hernia, "When in doubt, operate."

By watching carefully for the above indications, by resorting more frequently to operation when, at the end of 36 hours, it is clear that the mischief is not regressing, we shall, I believe, with confidence, reduce the mortality of acute appendicitis considerably. All must agree that this mortality is far too high when the advantages of modern surgery, when the accurate knowledge we have of the appendix, and when the age of the patients, are duly considered. How far the mortality, which we have seen to be reckoned by one of the first authorities at 14 per cent., will be reduced, is uncertain. I doubt, when all the conditions which surround a case of acute

appendicitis are duly weighed, if this mortality will be reduced below 8 per cent. And this gain, distinct as it is, will not be achieved unless much more frequently than is the custom at present, a surgeon is allowed to see the case which is causing anxiety at the end of 24 hours, and to operate if at the end of 36 hours there is still reason for anxiety.

ABSTRACT OF LECTURE ON THE BACTERIAL PURIFICATION OF SEWAGE (ESPECIALLY IN RELATION TO THE PREVENTION OF TYPHOID FEVER AND OTHER WATER-BORNE DISEASES).¹

BY CHRISTOPHER CHILDS, M.A., M.D.OXON., D.PH.

On Wednesday, November 7, 1900.

THE following were some of the principal topics dealt with in Dr. Childs' lecture :—

Importance of the subject from a sanitary and economical point of view. Popular opinions.

Desirable that medical men should be acquainted with principles, methods and results. Literature on the subject voluminous and confusing. Prolonged study required in order to form trustworthy opinion. Object of the lecture to give a brief summary of the whole matter.

The ingredients of sewage. Comparative failure of the old methods by precipitation and land-purification. Complete purification obtainable by the agency of bacteria alone.

The various stages of bacterial purification: (1) liquefaction, solution, and partial decomposition of the solid organic matters; (2) further decomposition and partial oxidation; (3) final and complete oxidation. The first stage carried out most effectively by anaerobic bacteria, air being excluded; the second stage by the ordinary aerobic bacteria with a moderate supply of air; the third stage by the "nitrifying organisms" with a copious supply of air.

¹ This important lecture will it is hoped be published in full in a volume of "POLYCLINIC LECTURES" now in preparation.

Various systems of bacterial purification: Scott-Moncrieff's, Cameron's, Dibdin's. Criticism of these systems. Results produced. Estimation of results by chemical standards.

Extermination of pathogenic bacteria in sewage. The pathogenic bacteria occurring or likely to occur in sewage. Are the bacillus typhosus and bacillus enteritidis sporogenes destroyed by the processes of bacterial purification?

Investigations which have been made to solve this question. Present uncertainty.

Desirability of destroying the bacillus typhosus at the first possible opportunity after it has left the body of the patient. Question as to how far thorough disinfection is carried out in private and in hospital practice. Systems of disinfection in cases of typhoid fever at the London hospitals.

The first and most important steps in purification, so far as the protection of the public from typhoid fever is concerned, must be taken at the bedside of the typhoid fever patient.

LECTURES ON RESUSCITATION FROM DROWNING, &c.

BY DR. BOWLES.

(Continued from page 282.)

IN 1863 I advanced another step, and in an experiment on a patient suffering from apoplexy with mucous stertor demonstrated that it was dangerous to change the position of the patient from one side to the other, as recommended by Dr. Marshall Hall; for, after the patient has been lying on one side for a time, the mucus and fluids gravitate into the lowermost lung, and upon the patient being rolled over on to the other side, the mucous fluid found its way across the trachea to the opposite lung, but in doing so, it had been whipped into foam with the ingoing air, which foam, by filling up the larger bronchial tubes, quickly caused suffocation of gradually increasing intensity.

Other cases soon after occurred in which I was able by experiment and by examination of the chest during life to confirm the

above observation, especially in a case of active hæmoptysis in which blood took the part of mucus.

Of course water, slightly inspissated with mucus, would necessarily follow the same course as blood in changing the side, and this I have fully proved *does* take place in cases of drowning.

Further, in one case in which I did *not* allow the side to be changed, pleuro-pneumonia supervened on that side *only* which had been lowermost. The change of side, therefore, which Dr. Marshall Hall had originally advised to be adopted during the use of his method must on these grounds, in future, be carefully guarded against.

I had become entirely convinced that the pronolateral positions were the only positions to be depended upon in the management of these cases, and that the removal of the tongue and epiglottis from positions of danger was a part of such management. The advice given by the Committee in 1862 "to open the mouth and draw the tongue forward" again raised the question of the possibility of treating cases in the supine position. I would refer to my account of our experiments in the supine position in 1856, in which obstructions were encountered in attempting artificial respiration on the dead subject, and I would quote as well the account of the dissection made by me at the time to ascertain the cause of such obstructions (Marshall Hall, "On Drowning," 1857, pp. 65 and 66).

"A middle-aged man, very much emaciated, having suffered for a long time from abscess of the brain; rigor mortis still present; the brain had been removed.

"*Experiment 1.*—Alternate pressure and relaxation on the thorax, the body supine; no effect.

"*Experiment 2.*—On pronation about one-third of the tube—on applying pressure, nearly the whole of the tube—was filled; on removing the pressure, the tube was emptied to one-third; and on resuming the lateral position it was quite emptied. These movements were several times repeated, and invariably with the like series of results.

"*Experiment 3.*—Experiment 1 was repeated. No effect was at first produced; but on pressure being applied by a *sudden jerk*, some obstacle seemed to be removed, and expiration was the result to such a degree that the tube was nearly filled, as in experiment 2,

and on removing the pressure the corresponding amount was inspired. After this, alternate pressure and relaxation, in the supine position, produced inspiration and expiration with ease. On removing the tube no obstacle was to be seen in the pharynx.

“*Remarks.*—Experiment 1 proves that in the supine position *something* does at times prevent respiration in the dead subject; and although in experiment 3, respiration was produced in this position, it could not be done at the beginning; some obstacle had first to be overcome, probably adhesion of the epiglottis to the back of the pharynx by viscid mucus, as the following observation would tend to prove.

“On cutting down and removing the right side of the pharynx with corresponding halves of the hyoid bone and thyroid cartilage, a good view of the position of the parts was obtained. The epiglottis was in direct apposition, by its laryngeal surface, with the posterior wall of the pharynx, so as to preclude the possibility of the passage of air. When, however, the head was allowed to hang backwards over the edge of the table, the bending of the cervical vertebræ caused the posterior wall of the pharynx to recede from the epiglottis, so as to allow the free passage of air. If the tongue had been drawn forwards, would the epiglottis have been removed from the pharynx? or would the prone position cause it to fall forwards?”

It will be seen by this, and especially by the question asked at the end, that I at that time doubted the propriety of trusting to the pulling forward of the tongue as a remedy.

In my paper on Stertor (*Med. Chir. Trans.*, 1860) is another dissection of the pharynx, which, besides “demonstrating the respective positions of the tongue with the opened and closed mouth, suggests the necessity of caution being used in raising the head with pillows; for if the head be too much bent forward on the chest, the tongue may lie in dangerous proximity to the pharynx, even if the mouth is closed.” This observation applied to the lateral position in a minor degree, but more especially to the *recumbent* position; and I never fail to adopt in practice the teachings to be derived from these dissections. I further made sure, by experimenting on myself, that dragging on the tongue’s tip would not affect its base or the epiglottis sufficiently to make it a *trustworthy*

procedure, as it was checked by the frænum; so, as before, I was driven to conclude that nothing could be ever safely trusted as a remedy in apnœa, drowning and comatose conditions whilst the patient was supine.

In 1873 Dr. Benjamin Howard, of New York, presented an essay to the National Lifeboat Institution; in it he says:—"The foundation of all true progress in the use of artificial respiration was first well and truly laid by Marshall Hall."¹ Dr. Howard had employed and taught both the Marshall Hall and Silvester methods, but in trying to obviate some defects which he found in them, he took a new line of departure, and advocated the employment of what he named the "Direct Method." He claimed for it greater exchange of air, greater facility and ease of application, and greater facility for the drainage of obstructive fluids, and says of it that it is more easy to be understood.

You all doubtless know that this method consists mainly of pressure on the lower ribs, in the supine position, the chest being elevated by a roll of clothing underneath the back, so that the chest is on a plane inclined towards the head, which is now at a lower level.

He has shown clearly enough that no doubt should now remain in the professional mind as to the existence of obstructions in the pharynx, and that they must be removed and the effectual drainage of the lungs provided for as the first step in the treatment of the apparently drowned. I am not, however, prepared to admit that his method of carrying out the details of the artificial respiration is the best possible. His objections to the Silvester method are evident and true, but his objections to the Marshall Hall method are neither evident nor true.

In the Marshall Hall method, slightly modified to embrace the corrections of experience, we have, I believe, the best of all methods.

- (1) It is truly a very "ready method," and requires no apparatus.
- (2) The instructions are easy to be understood by ordinary unprofessional people.
- (3) On account of the immediate adoption and continued use of

¹ *Lifeboat*, Feb. 1, 1873, p. 381.

the pronolateral positions, this method is more to be trusted than any other for keeping the pharynx clear of obstruction.

(4) It empties the stomach and gradually clears the lungs of the watery and frothy fluids, and will surely and gently introduce sufficient air at each inspiration to take the place of the fluid which has been expressed.

(5) The pressure, applied to the back when the patient is prone, exerts an influence on the heart, the blood is moved onwards towards the lungs, which are by the next movement opened up to receive it, and thus the right side of the heart and the cerebral vessels are relieved of the engorgement which we know to exist.

(6) The safety of the patient is more perfectly secured by keeping him on one side during the whole treatment, one lung being thus kept quite free.

(7) In apnoea, or, after a time, in drowning, when the upper lung is believed to be freed from water and frothy mucus, if more air is required it can be introduced by elevating the upper arm above the head each time the patient is turned on his side, an addition, in part, of the Silvester to the Marshall Hall treatment.

A patient in a state of apnoea or syncope with greatly diminished circulation needs but little air for the preservation of life, and in drowning still less, on account of the presence of water in the lungs. It would be better to lay the patient on one side and trust to nature alone than to have recourse to measures which would cause the forcible inspiration of air, before the evacuation of water had been successfully effected. Artificial respiration, although undoubtedly the best and really only remedy when properly applied, becomes a source of increased danger if used injudiciously and too violently. It is not necessary in the Marshall Hall method to place a roll of clothing, or anything else, to elevate the chest when the patient is prone; we found by experiment that elevating the chest, even for a few inches, when the patient lay on his face, caused expiration.

You will observe, gentlemen, that I have not alone passed in rapid review the general question of drowning, but I have demonstrated some new principles upon which our future treatment of apnoea from whatever cause should be based—principles not theoretical, but which have stood the test of time and of experiment and have been already many times successfully applied in practice.

NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

MEDICAL CASES.

BY DR. BOWLES.

November 6.

I.—A CHILD of 8, said to have had rheumatic pains three years ago, and again fifteen months ago, but there was no history of rheumatic fever, nor was there a family history of that disease. About a year ago the heart was observed to be tumultuous in its action.

The child is undersized and thin, and the heart movements can be seen over a considerable area of the chest wall; the apex beat is diffuse in the sixth interspace and $1\frac{1}{2}$ inches to left of nipple, and percussion dulness extends slightly to the right of the sternum. In the mitral area systolic and diastolic murmurs are to be heard, and a diastolic murmur at the base; there is some bronchial catarrh and enlarged tonsils.

II.—A girl, aged 14, has a history almost identical with the preceding: attacks of "rheumatics" without evidence of fever; but there is evidence of her illness having followed on measles. There is, as you see, excessive pulsation in all the large vessels of the neck and a forcible apex beat in the fifth interspace in the nipple line, and the percussion dulness extends half an inch beyond the right sternal edge.

The pulse is soft and collapsing, the water-hammer pulse.

There are well-marked double aortic murmurs and double murmurs, in the mitral area, but, from the absence of thrill, of the sharp snap at the end of the diastole and other evidences of mitral stenosis, it is almost certain that this diastolic sound is communicated from the aorta. In both cases, with favourable hygienic conditions and suitable treatment during development, much may be done by Nature in the way of compensation and improvement,

but of course the future lives of both these children must necessarily be full of risks and anxieties.

III.—A woman of 50 years of age, with a history of biliary colic for about three years, dyspepsia for six months, and jaundice for the last four months. Now the history of this case is of considerable importance, and, unfortunately, it is correspondingly difficult to obtain it with accuracy on account of the want of intelligence of the patient. On close questioning, she distinctly asserts, as you hear, that during her earlier attacks of pain she never had jaundice, her motions were never pale, and she had no vomiting; this does not sound like obstructive jaundice. Her liver is now enlarged, and was said to be tender; but now she declares that the tenderness is on the left side and not over the liver, that she has lost $1\frac{1}{2}$ stone of weight during the last twelve months, especially since the jaundice came on, that her motions then became pale and her urine dark, but that now the motions are assuming their natural colour. If we can depend upon these assertions, with the judicious treatment she is now receiving, we might have hope of an early recovery, and the more so from the facts that no tumour can be detected and that vomiting did not long precede the jaundice. Of course, her extreme stoutness, her age, and perhaps her habits, must be placed in the opposite scale.

IV.—This man, 37 years of age, is an officer in the Salvation Army. You see he looks depressed and anæmic, with a muscular development exceptionally good. He complains of pain just outside the mitral area, shortness of breath on exertion, and an inability to lie on the left side. He was a miller, and was then strong and well. Three or four months ago he began to feel exhausted and short of breath at the conclusion of his meetings. His appetite is now poor, and he is troubled with flatulence.

At first sight one would assume that dyspepsia, anæmia, and nervousness would account for all his symptoms, but, on percussion, it is quite clear that there is increased dulness in the mitral area and the apex beat is outside the nipple line about where he complains of pain. There is no murmur. It is, therefore, almost certain that, with his flabby condition and lowered nerve tone there is some temporary dilatation of the heart, which, with rest and change of air and iron and digitalis, he may entirely recover from.

V.—A carpenter, aged 54. Cough, expectoration, and shortness of breath for many years. At 26 he suffered from fever in Mauritius, from which he completely recovered. Three years ago he began to lose flesh, to get weak, to cough, and to expectorate. He had night sweats at the beginning of this illness, but they all passed away. He has never suffered from hæmoptysis. He is now thin, worn, and preternaturally old-looking, and has palpable dyspnœa with prolonged expiration. Phthisis is suggested, but on examination of the chest only the phenomena of emphysema are disclosed; there are no present signs of tubercular deposit or of cavities, and he declares that his expectoration has never been purulent. There may be some hidden tubercle, but it is not now to be found.

SURGICAL CASES.

BY W. JOHNSON SMITH, F.R.C.S.

October 24.

I.—*Inflammatory Induration of Biceps, probably syphilitic.*

A Belgian seaman, aged 24, came under notice at the Seamen's Hospital, Greenwich, with thickening and very marked induration of the biceps of the left arm, which had come on suddenly, without any evident cause, about one week before his admission. The swelling was strictly limited to the biceps, the other flexors of the forearm and the deltoid remaining in a normal condition and presenting a marked contrast in their consistency to the affected muscle. The swelling was a painful one, preventing sleep and causing depression and general disturbance. The evening temperature was a febrile one, ranging from $100\cdot2^{\circ}$ to 101° . As the skin was slightly œdematous, though not altered in colour, a deep incision was made into the muscle on the outer side of the limb. This gave exit to about two drachms of thin and turbid fluid of a yellow colour. As no relief was afforded by this or by local applications, iodide of potash was given in large and frequent doses. Very soon after the commencement of the medicinal treatment the pain ceased

and the hard and swollen muscle rapidly regained its normal condition. When the patient was shown at the Polyclinic ten days after the commencement of the "iodide" treatment, the induration, which was then but slightly marked, involved only the upper half of the muscle. The good and rapidly developed results of this treatment, and a history of syphilis contracted about four years previously, led Mr. Smith to diagnose this as a case of tertiary interstitial myositis, which affection, according to the observations of Ricord and others, shows itself by preference in the muscles of the upper extremities, and especially in the flexors of the forearm.

II.—*Sarcoma of the Radius.*

A man, aged 34, was presented, from whom, about six weeks previously, the lower third of the left radius, together with the corresponding portion of the ulna, had been resected for the removal of a large and rapidly-growing tumour of the first mentioned bone. This tumour, on examination before the operation, seemed to be hard and resistant and, as pictured in an excellent skiagram prepared by Mr. Montague, presented the appearances of a solid myeloid sarcoma. At the operation, however, it was found to consist of a thin and very friable envelope of bone enclosing soft blood clot. The thin layer of bone gave way very readily and much difficulty was experienced in removing the whole of the diseased portion of radius. In the course of the operation, which consisted in a long dorsal incision over the radius, the radial artery was wounded but not a single tendon was divided. Microscopical examination of soft material spread over the inner surface of the osseous capsule showed that the growth was a spindle-celled sarcoma. The patient, when shown at the Polyclinic, was able to move freely the hand and fingers and, with the wrist supported by a thin casing, could lift with ease a chair and other heavy bodies.

III.—*A Case of supposed Secondary Tuberculosis of Bladder with profuse recurring Hæmaturia.*

A Norwegian seaman, aged 34, was presented, with the following clinical history. Was admitted into the Seamen's Hospital, on September 8, with profuse and persistent hæmorrhage from the

bladder and urethra. This was the sequence of several previous attacks of varying length and severity. The first attack, a short and slight one, had occurred about twelve months before the time of his admission. After this the man, from time to time, especially after exposure to wet and cold at sea, had other slight attacks, but during the six months before admission suffered from two attacks, each of which was very severe and caused him much anxiety and alarm. The attack of bleeding—the third one in the course of six months—for which this patient was admitted was very severe and lasted over ten days. Then it suddenly ceased and from this time he has remained almost quite free, having noticed just a trace of blood in the urine on two occasions only. During a stay of two months in the Seamen's Hospital this patient remained in good general health and presented no indications of serious renal or bladder trouble. His urine, as a rule, was quite clear, acid, and free from albumen, but occasionally deposited, after standing, some scanty flakes of soft and white substance. He was able, with some effort, to "hold his water for over six hours and then passed 14 ozs. of quite clear urine. The average quantity of urine passed in the twenty-four hours was 50 ozs. There was no tendency to "loss of flesh."

On an attempt to explore the bladder after the cessation of the bleeding there was found to be an obstruction in the prostatic portion of the urethra, and the passage of a sound caused extreme pain. On rectal examination there could be felt in and beyond the region of the prostate a very large and very hard swelling which was irregular on its surface and became more and more nodulated as it extended along the floor of the bladder.

With regard to the nature of this swelling there were several points indicative of its being a malignant growth, especially the profuse and repeated hæmorrhage, its size and firmness, and the nodular irregularity of its surface. On the other hand the age of the patient was against this view, and also the absence of any signs of cachexia. The general condition of the man was good and there was neither local glandular enlargement nor external manifestation of any secondary growths. The size and uniform hardness of the swelling, taken together with freedom from urinary troubles, seemed at first to exclude the diagnosis of tuberculosis, but a careful con-

sideration of the chief clinical data of the case led to the conclusion that the swelling was really caused by a tubercular enlargement of the prostate and probably also of the the vesiculæ seminales. Two years previously the right testis had been removed in New Zealand for a large, hard swelling which had "broken down." On examination of the chest signs were revealed which were suggestive of tubercular disease in one apex and decidedly indicative of tubercular deposit in the other. The scanty urinary deposits of white, soft flakes showed under the microscope pus cells and some few and widely scattered though very decided specimens of tubercle bacillus.

LARYNGOLOGY AND OTOTOLOGY.

BY HERBERT TILLEY, M.D., F.R.C.S.

November 9, 1900.

I.—*Case of Lupus of the Nose.*

The patient was a girl aged 22 years. The interesting feature in the case was the fact that the disease started in the right nostril, and did not, as usual, extend into it from the face. The lupoid nodules were confined to the anterior part of the floor of the nose and the anterior end of the right inferior turbinate. Increasing nasal obstruction was the prominent symptom. Under general anaesthesia the infected area was thoroughly curetted, then dried, and 80 per cent. lactic acid rubbed in. It is two and a half years since the operation, and the disease has not recurred. The diminution in the vertical depth of the ala nasi illustrates the cicatrising power of the lupoid scar. When the disease attacks the septum nasi it may result in perforation of that structure, and may be mistaken for a syphilitic lesion; but, as Mr. Jonathan Hutchinson has pointed out, syphilis is only one of the causes of perforation of the septum nasi.

II.—*Two Cases of Cured Chronic Frontal Sinus Empyemata.*

The interesting features in these cases were:—(1) The almost invisible scars in the line of incision at the inner ends of the eyebrows

and (2) the small amount of recession of the soft parts, in spite of the fact that nearly all the anterior wall of the sinuses had been removed.

The importance of making a free opening from the sinus into the nose was dwelt upon, and also the necessity of removing all intranasal obstructions, such as polypi and the anterior end of the middle turbinal, before undertaking the external radical operation.

An improved syringe for washing out the maxillary antrum was also demonstrated.

III.—*Case illustrating the Radical Operation for Chronic Mastoid Antrum Suppuration, in which Thiersch's Method of Epithelial Skin-grafting had been applied.*

In this patient, a woman, aged 32, this method of dealing with the tympano-attico-antral cavity had been adopted, and the patient had a perfectly dry ear five weeks after the first operation. The main essentials for a successful operation were:—(1) To smooth down all irregularities of the bony cavity formed by throwing the meatus, tympanium, attic, and antrum into one large cavity; (2) to remove every focus of disease, so that the graft was applied to a healthy granulating surface; (3) firm application of the graft to the surface it was desired to cover; and to secure this, all oozing of blood must be checked before the graft is placed in position; and (4) to ensure firm pressure on the graft for three or four days, it should be covered with gold foil, upon which strips of gauze are packed. In children the interval between the first operation and the grafting was about a week, in an adult about a fortnight, although these times would vary according to the rapidity with which granulation grew after the first operation.

The advantage of the grafting to the patients was that they had a "dry ear" in the course of five to six weeks; whereas, formerly, it was often seven or eight months before the granulation cicatrised and the daily ear toilet could be neglected.

DERMATOLOGY.

BY MR. MALCOLM MORRIS.

November 12.

I.—A man, aged 46 years, who had suffered with a pruriginous eruption from early childhood. The skin was rough and thickened from continual scratching. He also suffered from spasmodic asthma and rheumatoid arthritis and there was a marked history of insanity.

II.—A woman, aged 47, who presented a small patch of lupus erythematosus on the right cheek; the follicles were plugged with sebaceous matter and the surface covered with yellowish crusts. The disease also affected the inner surface of the left ear.

III.—A man, 43 years of age, with a serpiginous syphilide attacking both palms.

IV.—A case of tertian syphilis, chiefly affecting the face.

V.—A boy, aged 15, shown before, with movable subcutaneous nodules on the extensor surfaces of the forearms and legs, and in other parts of the body; he was also "elastic-skinned," and suffered from hæmorrhages into the skin resulting from pressure or slight injury. Sections of the tumours and of the skin were shown.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. JONATHAN HUTCHINSON.

(Continued from page 290.)

The consultation on Thursday, October 18, was concerned with the following cases:—

I.—A girl, aged 19, with rheumatic arthritis of a hip joint. (Dr. Couper Cripps.)

II.—A man, aged 63, with epithelioma of the tongue, presenting very unusual features.

III.—A child, aged three years, the subject of "Funnel chest." (Dr. Warner.)

IV.—A man, aged 31, the subject of a very large varicocele, with dartoplegia. (Dr. Rocher.)

V.—A married woman, aged 36, very fat, with a fatty tumour on one shoulder. (Dr. Davies.)

At the conclusion of the consultation a demonstration was made of a mammary gland, with several glands from the armpit, which I had removed on the previous day. The section of the growth, which was a hard scirrhus, showed the peculiarity of ecchymotic mottling and staining of various tints of orange and yellow, like those of a myeloid tumour. The axillary glands showed precisely the same blotches of colour. There was no history of any injury, and the tumour, which was of recent growth, had not been attended by pain. The specimens were remitted to the Pathological Laboratory for further examination.

Other specimens, illustrating Vegetable Pathology, the formation of galls, and the discolouration of leaves in connection with the attacks of parasites and other causes, were shown.

On Thursday, October 23, the following were the chief subjects of consultation:—

I.—A case of herpes of the tongue and mouth in a delicate woman. The herpes had recurred so frequently that she was scarcely ever free. It was very rarely on both sides at the same time. She had suffered from it for many years, and in early life had been liable to herpes labialis.

II.—A woman of about 46, who was the subject of Raynaud's phenomena in a definite, but not very severe form.

III.—A man with an eruption of recent development and acne type in face and forehead. The use of bromide or iodide was suspected, but denied.

Amongst the cases which attended for consultation on Thursday, November 1, were the following:—

I.—Lupus erythematosus of the sebaceous form. Patient a delicate-looking man of 35, who had spat blood in his youth, and one of whose brothers had died of phthisis.

II.—Extensive destruction of the palate, vomer, &c., from chronic syphilitic disease still not cured. The patient, a man of 41, had suffered from syphilis at the age of 21, and in spite of much treatment had had disease in his nose and mouth almost ever since. In

all other respects he had retained good health. He had married and had fine healthy children. Advised chinosal and iodides in large doses. (Dr. Frederick Davies.)

III.—A case of pustular sycosis of upper lip in a cachectic man, the subject of chronic rhinitis. (Dr. St. Clair Thomson.)

IV.—A case of the so-called xanthoma diabeticorum in a healthy man who had no glycosuria and no evidence of liver disorder. (Dr. Stephen Mackenzie and Dr. Sinclair.)

V.—A case of very severe headaches in a very florid man of 40, who had been threatened with gout and had a pulse of high tension, and for whom much treatment had been tried in vain. Headaches preventing sleep. Advised absolute vegetarianism, purgatives and hot pediluvia. (Dr. Corbet Fletcher.)

Amongst the patients who attended on November 8 were :—

I.—A case of pityriasis rosea in large erythematous and furfuraceous patches on the trunk, neck, and upper arms of a girl of 10. The eruption had been out three weeks. No parent-patch had been observed. (Dr. Poynton.)

II.—A case of pityriasis rosea of the ringed type in a married woman of 30. Many of the areas were very large, but some in the upper arms were small and indistinguishable from ringworm. The parent-patch had been on the neck. It had been present one month. (Dr. Corbet Fletcher.)

After discussing the diagnosis from syphilis and from ringworm respectively, I commented upon the spontaneous curability of the disease and the non-liability to relapse. I advised the use of the Harrowgate water-bath, and remarked that although there could be but little doubt that the disease was due to some parasitic cause, none had as yet been identified, and it never appeared to spread in the family. All our examples of it were isolated ones.

III.—A good example of lichen-acne of the trunk, apparently located by the vest. (Dr. Sequira.)

IV.—A young man of 19, in whom, since August last, a rounded tumour had been growing over the inner condyle of left femur. Diagnosis, periosteal sarcoma, and amputation advised. (Dr. Stocker, of Forest Gate.)

V.—A schoolmaster of 46, in fair health, but supposed to have chest delicacy, in whom a warty ulceration involved the whole anterior pillar of fauces.

VI.—A woman of 63, the subject of ectropium of the lower lip and with bald and beefy tongue, the results of syphilis thirty-six years ago. I had myself attended her for the original disease. She had enjoyed excellent health ever since, with the exception of her local trouble, and had a son aged 33 and four grandchildren, all in good health.

VII.—A woman of 30 suffering from crusted prolabium of the whole of both upper and lower lips and crusts in the nares.

VIII.—The girl who has been several times mentioned before, in whom gummata of the tongue in association with sclerosis of the tibiæ have produced some difference of opinion as to whether she is the subject of inherited or acquired syphilis. The history as regards inheritance was not only negative, but appeared to be very improbable. The question has, however, been finally decided as the development of acute interstitial keratitis. The details will be published.

The following were some of the cases on November 15 :—

I.—(Mr. J. Garrett, of Acton.) A young woman with paralysis of her left ulnar nerve after a contusion of its trunk behind the elbow. The muscles were all wasted, and sensation so completely lost that she had burned her little finger without feeling it. The injury had been a severe knock on an iron bedstead. It was quickly followed by a burning sensation in the forearm, and subsequently by coldness. There had been no pain. Pressure on the trunk no longer caused tingling in the fingers, as was easily done on the sound side. I suggested the prescription of small doses of mercury, on the theory that it was a form of neuritis.

II.—(Dr. Rocha.) A case of congenital ptosis in a young man. As he was engaged as a shoemaker it did not cause him the slightest inconvenience.

III.—A very remarkable example of severe bullous urticaria after fish poisoning. This patient was brought by Mr. Carr, of Deptford, who also brought with her a coloured portrait representing the eruption when fully out. This portrait (by Burgess) showed the face, trunk, and limbs covered with a florid papular eruption, which was bullous in parts. The lips were thickly crusted. The history was that the woman had, with her mother, supped on cod-fish; that ten minutes after her supper her eyelids began to itch,

and in the course of a few hours the face was involved in swelling. Then followed a sharp illness, and the patient was in bed several weeks. It was now more than a month since the attack, and for the most part stains only remained. There were, however, a few new vesications occasionally appearing about the neck. All the nails were in process of exfoliation, the affection beginning at the nail root by loosening of the nail from its bed. The lips, which had in the first instance been covered with crusts, were now clear. The woman stated that she had often taken fish before with impunity, that she had never before had nettlerash, and that the same fish had on this occasion not disagreed with her mother.

IV.—(Dr. Dixon.) A child, 2 years old, with periosteal dactylitis of one finger and strumous abscesses in cellular tissue at several parts. These strumous conditions had followed an attack of measles.

V.—(Dr. Conner.) A girl of 22, in whom the left mammary gland was swollen and painful, with a history of previous glandular swellings in the neck. A suspicion had been raised that she was the subject of congenital syphilis, for her cornea were hazy and the right eye convergent and very defective. Her mother had had fourteen miscarriages, and had only three living children. The patient, however, neither in physiognomy nor teeth showed anything conclusive. She had chains of hard glands in both sides of the neck and a considerable mass in the left axilla, which had suppurated. Some years ago, at the Margate Infirmary, glands had been excised from both sides of the neck. The mammary gland itself was now swollen and extensively indurated, but not acutely inflamed, and not threatening abscess anywhere. I diagnosed the case as one of lymph-adenoma of the strumous type, and remarked on the rarity of any implication of the mamma in such disease. The question as to inherited syphilis was left undecided. The suspicion chiefly rested on her mother's volunteered statement that she believed that her husband had had the disease.

VI.—A man of 50, looking in excellent health, with a very hard tumour placed obliquely under the upper part of his right sternocleido-mastoid muscle. The tumour was as large as a child's fist, and very hard. It was slightly nodulated on its surface. It passed forwards under the angle of the jaw, and evidently had deep attach-

ments. Lower down in the neck was a single rounded gland, quite loose and very hard. The tumour had been present eight months, and was increasing. There was no disease in the throat and nothing in the other side of the neck.

I remarked that the case was a good example of a peculiar form of primary glandular sarcoma, which I have been accustomed to call "the potato tumour" of the neck. It occurs only in this region, and examples of it bear very close resemblance one to another. The mass usually consists of a single hard lump, much like a kidney potato, and placed obliquely close under the angle of the jaw. It is always one-sided and always primary. Although probably beginning in a gland, there is seldom any evidence of implication of separate glands or of the adhesion of many together to constitute the potato-like mass. The prognosis is very bad, for the growth is rapid.



This wood-cut, although, of course, not belonging to the case now recorded, shows well the position assumed by the lympho-sarcomatous tumour under consideration. It is from a photograph taken many years ago.—J. H.

COLLEGE NOTES.

BY THE DEAN.

DURING the month of October eighteen new members were admitted to the College.

* * *

THE Clinical Lectures during December will be delivered on the 5th by Sir Hector Cameron, of Glasgow, whose subject of discourse will be "Clinical facts concerning Surgical Tuberculosis"; and on the 19th by Dr. Burney Yeo, on "The Treatment of Tubercular Peritonitis."

* * *

THE Council have learned, with much pleasure and gratitude, that valuable additions have been made to the library during the past month by donations from Dr. Radcliffe Crocker and Dr. Stowers.

* * *

IT has been represented to the Council that a short holiday course of practical tuition, at an inclusive fee, would be acceptable to many provincial practitioners who come to town for a few weeks and are desirous of putting in the maximum of work within the limits of their available time. The Council have agreed to meet the wishes of those who have brought this matter before them, and have authorised arrangements being made for a condensed course of practical classes during the last three weeks of September, admission to all of which will be covered by one composition fee of five guineas. Should the course prove successful and attract a large attendance, others such might be provided throughout the year, but this first one is to be looked upon as tentative only. Full details concerning it will be published by-and-by, but its fixture is mentioned now that members may be aware of this further proof of the Council's desire to make provision for the convenience of all who seek to do work at Chenies Street; and also to enable them to let the fact of this prospective course be widely known among their provincial friends who may be likely to avail themselves of the

opportunity. This new departure necessitates a reduction in the number of sessions of practical classes; in future four, instead of five, will be held annually.

* * *

ONE hundred and two patients were present at nineteen consultations during the month of October. The cases were varied, and covered, as usual, a wide field of clinical observation.

* * *

As we are rapidly approaching the end of another year, and this will be the last number of the POLYCLINIC to appear under the date 1900, it may be of interest to recapitulate the clinical lectures which have been delivered at the College during the first eleven months, together with those for the current month which have not yet been given, but which complete the series for the year. It will be remembered that the first lecture was given in June of 1899 by Professor Clifford Allbutt on "Parkinson's Disease," but it was not until January of the present year that arrangements were completed for systematically carrying on the work which was then so ably inaugurated.

Most of these lectures have been published, either *in extenso* or in abstract form, in the *Lancet*, the *British Medical Journal*, the *Clinical Journal*, or in our own columns. A suggestion has been made that these lectures should be edited annually in volume form, but no final decision has yet been come to. An expression of opinion on the subject from our members would be valuable.

* * *

THE new card of events for the first months of 1901 will be in the hands of members within the next fortnight. As will be seen from its perusal, we again have reason to be grateful to many of the leading members of our profession for the continued assistance in the department of our work which comes under the heading of Lectures and Consultations. Many members think that our Clinical Lectures should be given once in every week instead of every fortnight, but this would be difficult at present to manage unless the work of the intervening days were relegated to Saturday, and it is doubtful how far either consultants or practitioners would find such an arrangement convenient. Captain Pinch will be very glad to hear any expression of opinion from members on the subject.

| DATE. | TITLE. | LECTURER. |
|---------------------|--|--|
| 1900. January 17 | "Insomnia" | Sir Wm. Broadbent, Bart., M.D., F.R.S. |
| ,, 31 | "Mental Dissolution" | Geo. H. Savage, M.D. |
| February 9 | "The Value of Tuberculin in Diagnosis and Treatment" | Prof. McCall Anderson, M.D., Glasgow. |
| ,, 21 | "Malaria Parasites and Malarial Disease" | Patrick Manson, M.D., F.R.S. |
| ,, 28 | Ditto | Ditto. |
| March 14 | "Non-diabetic Glycosuria" | Robert Saundby, M.D., Birmingham. |
| ,, 28 | "The present day Treatment of Syphilis" | Jonathan Hutchinson, F.R.S. |
| April 11 | "The Clinical Relations of Arthritis" | W. Miller Ord, M.D. |
| ,, 25 | "Some Clinical Types of Cirrhosis of the Liver" | Julius Dreschfield, M.D., Manchester |
| May 9 | "Elephantiasis" | Col. Kenneth McLeod, M.D., Netley. |
| ,, 23 | "Clinical Memories" | Sir Wm. T. Gairdner, M.D., F.R.S., Glasgow. |
| June 6 | "The Importance of Early Diagnosis and Operation in Surgical Diseases of the Abdomen" | Wm. Rose, F.R.C.S. |
| ,, 20 | "Jacksonian Epilepsy" | David Ferrier, M.D., F.R.S. |
| July 4 | "The Teaching of Practical Medicine" | Prof. Osler, M.D., Baltimore. |
| ,, 18 | "Chronic Pancreatitis, its simulation of Cancer of the Pancreas and its Treatment by Operation, with illustrative cases" | A. W. Mayo Robson, F.R.C.S., Leeds. |
| September 12 | "The Diagnosis and Treatment of Intracranial Tumour" | Byrom Bramwell, M.D., Edinburgh. |
| ,, 26 | "Some Diseases of the Aorta, not due to Rheumatism" | Arthur E. Sansom, M.D. |
| October 10 | "The Diagnosis of Epilepsy" | Sir Wm. Gowers, M.D., F.R.S. |
| November 7 | "The Bacterial Purification of Sewage; especially in relation to the preven- tion of infection by Enteric Fever and other water-borne diseases" | Christopher Childs, M.D. |
| ,, 14 | "Some remarks on the question of early operation in Acute Appendicitis" | W. H. A. Jacobson, F.R.C.S. |
| ,, 21 | "Plague" | James Cantlie, F.R.C.S. |
| December 5 | "Clinical facts concerning Surgical Tuberculosis" | Sir Hector Cameron, M.D., Glasgow. |
| ,, 19 | "The Treatment of Tubercular Peritonitis" | J. Burney Yeo, M.D. |

THE total attendance at the College during the month of October was 1219, being 177 in excess of any previous monthly record.

* * *

MR. FREYER'S course of lectures was a great success. The practical points in diagnosis and treatment as applied to surgical disorders of the urinary tract were insisted upon with commendable terseness and with sufficient vigour to drive them well home—not only into the minds but into the note-books as well—of those present.

* * *

THE Hospital Association Scheme is gradually assuming shape. The arrangements are not sufficiently matured to warrant more than a general statement on the progress of the negotiations, but it may be of interest to know that conferences have been held within the past few weeks with representatives from several hospitals, and that up to the present ten general and special hospitals have expressed a favourable compliance with the broad outlines of our scheme and have agreed with us as to the terms on which it may be worked out so as to meet the views of the Polyclinic on the one hand and of the hospitals on the other. Our Council desires to make the arrangement so wide that for a small fee our members will have it in their power to get a large choice of hospitals, and the hospitals which have been represented at our conferences are not less anxious to afford such opportunities as will give to our members the fullest advantages of all the work carried on within their walls. It is hoped that by the beginning of 1901 a certain number of hospitals will be on our register and open for the reception of our students, but the full elaboration of the scheme will take time. Ultimately it is anticipated that it will be possible to reach through our office most, if not all the hospitals of London. The clinical material available is enormous, and even if the larger hospitals with attached medical schools be meantime excluded—and there are obvious reasons why it is difficult for them to arrange for the reception of both undergraduates and post-graduates—there remains a wealth of bedside and out-door hospital practice, most of which, it is hoped, will ultimately be brought within the reach of those of our members who desire clinical facilities of that sort.

THE special courses of lectures for the first three months will be given: in January, by Mr. Tubby, on "Surgical Abdominal Affections of Childhood"; in February, by Mr. Bland Sutton, on "The Surgery of Pregnancy and Labour complicated by Tumours"; and in March, by Mr. George Rowell, on "The Administration of Anæsthetics."

Each course will consist, as formerly, of three lectures, the precise dates of which will be found in our new schedule now in process of preparation.

It has been recently decided to increase these special courses to two a month instead of one, but the arrangements are not yet sufficiently advanced to announce either who the additional lecturers, or what their subjects, will be.

* * *

IN his address to the students of St. George's Hospital at the distribution of prizes on November 6, Sir Michael Foster stated that he had just returned from America, where he had repeatedly heard the opinion expressed that though the training of the ordinary student in England was of unsurpassed excellence, the facilities for post-graduate instruction were wholly inadequate. He threw out to members of hospital staffs the suggestion that by well-directed organisation this reproach might be easily overcome. Obviously, Sir Michael Foster is unaware of our existence, and of the endeavours we are making, and successfully, to provide the opportunities which his American friends pointed out to him were so much wanted in England.

A young institution requires to develop gradually, and though the Polyclinic is still in its babyhood, and therefore not known of all men, it is already making its influence felt both at home and abroad. Within recent months the attendance of American, Colonial, and foreign graduates has been so numerous that ere long the fact will be universally known that London has at length bestirred herself in the matter of post-graduation work, and that opportunities, which are being widened and amplified every day, are now afforded at Chenies Street for the practical prosecution by qualified medical men, at a small cost, of work in every department of medicine and surgery, in the laboratory, lecture theatre, and at the bedside.

CATALOGUE-COMPANION TO THE MUSEUM.

TURNING to the right on entering the Museum by the gallery door, the visitor will find arranged a series of portraits illustrating affections produced by exposure to sun and air. Beginning with an extreme example of ordinary sun-tanning and others of freckles he will pass on through sun-blistering and Pennmann's prurigo-acne to the family form known as xerodermia pigmentosa and the senile ones of melanosis and multiple epitheliomata.

AFFECTIONS OF THE SKIN DUE TO EXPOSURE TO SUNLIGHT
(INSOLATION MALADIES).

The following are brief particulars of the portraits displayed in this series. They may be roughly grouped as follows :—

Group I.—Effects of the Sun in producing Diffuse Pigmentation of the Skin.

No. I.—Under this head we have the portrait of a young woman in whose case the diagnosis of Addison's disease was given in error. The portrait was taken in the belief that disease of the suprarenal capsules existed, and that a fatal result would follow. The patient came under care on account of general weakness and had complained much of pain in the back. Under tonic treatment, however, she regained her health, and during residence at her home in London the deep brown tint of her face disappeared. The sequel invalidated the diagnosis and made it seem probable that all that is shown in the portrait was the result of exposure to the sun at the seaside. The patient had only just returned from the sea when the portrait was taken. It is of interest as showing the extent to which sun-tanning may go and, further, that it is not always persons in strong health who brown the most.

Group II.—Effects of Summer Sunlight and Heat in producing Pruriginous Acne, Bullous Eruptions, Ulcerations, &c.

No. II.—The original portrait of a boy named Pennmann, whose case has been repeatedly described and whose portrait is copied in

the "New Sydenham Society's Atlas." It may be suggested that it should stand as a type-case of what may be known as "Pennmann's summer-eruption." The lad was under observation many years, from boyhood to about the age of 18, when he finally got rid of his proclivity. His eruption consisted in a great number of very pruriginous papules resembling acne, but never becoming either pustular or comedonous. They occurred chiefly on the exposed parts, but also to some extent on the trunk. He was always well in winter and relapsed in summer.

No. III.—A portrait showing the face and hand of a lady of middle age. The eruption has almost exactly the same features as that of Pennmann. It had begun in early life, but had not ceased, as did Pennmann's, on reaching adult age. It was always worse in summer, but did not always get quite well in winter. Its occurrence on the backs of the hands distinguishes it definitely from all other forms of acne.

No. IV.—The portrait of a lad whose clinical history was exactly that of Pennmann, but in whom the eruption, which recurred regularly every summer, was attended by large bullæ and extensive ulcerations. This lad was under Mr. Hutchinson's observation many years, and finally, when he attained adult age, the liability ceased. It left him, however, much disfigured by scars, and the fleshy parts of the ears were almost wholly destroyed. He was always well in winter. His case has been published.

No. V.—The portrait of a young woman, who was repeatedly during the summer months an inmate of the Leeds Infirmary, under the care of Dr. Eddison. Her face and upper part of bust are covered with large scars, and in a separate sketch of one of her ears it will be seen that the fleshy helix and lobule have been destroyed. Her history, excepting in its greater severity and in that although always very much better she did not always get quite well in winter, was a very close parallel to that of the subject of the preceding portrait. It will be noted that the ulcerations tended to heal soundly, and that, however extensive, they never degenerated into chronic sores, or in any degree simulated lupus. They were never in the least serpiginous.

It is of much interest here to note that the liability to tan and to freckle from exposure to sunlight is usually in inverse ratio with the liability to blister. Those who tan do not blister, and conversely.

This is observed not only in youth, but, as we shall see, it recurs in old age.

No. VI.—The subject of this portrait was a girl of 5, whose skin was remarkably sensitive to the influence of the sun. All that is shown in the portrait was consequent upon a walk in the country on a day of bright spring sunshine. Before the exposure her skin was quite sound. It will be seen that her face, forearms, and backs of hands, are covered with bullæ and much inflamed. Unfortunately, beyond the fact that she soon got well of this attack, nothing has been ascertained as to her subsequent history.

Group III.—Effects of Sun and Exposure in producing Local Pigmentation of the Skin (Lentigo, Freckles).

In connection with a special anatomical distribution of pigment, to which as yet not much attention has been given, the skin of certain regions, notably the face and hands, is liable to show local accumulations of brown pigment. To these the name of Freckles (Lentigo) has been given. It is well recognised that different persons are liable to freckle with very different degrees of severity, and it has been suspected that a remarkable proneness to freckle is often coincident with tendency to scrofula or tuberculosis. It is most certain that such proneness is associated with the temperament of the individual as shown by colour of eyes and hair. Our portraits illustrating Freckles are two in number.

No. VII.—An excellent delineation of the face of a boy with hair of a red chestnut tint and blue eyes. His face is covered with brown freckles, which are especially abundant about the eyelids. It is from "Alibert's Atlas" and is designated Ephilide lentiforme.

No. VIII.—A portrait from "Hebra's Atlas." It is that of a girl with carrot red hair and blue eyes. The abundance and distribution of the lentigenes is much the same as in the French portrait. The hands also are shown.

We may note with interest that not only are these two subjects of Freckles alike in complexion, but they are also of much the same age. Freckles are as a rule conspicuous only in the clear skins of children and young persons. In adults they are either not often present or are comparatively inconspicuous. An observation of

some interest has, however, recently been made that they are liable to return in senile periods and to assume infective characters.

From the portraits representing common freckles we pass by a quite natural transition to those which illustrate the malady known as Xerodermia Pigmentosa, Kaposi's disease, or *Lentigo juvenilis maligna familiaris*.



Xerodermia pigmentosa in an early stage (Lentigo maligna juvenilis). Portrait of a child under the care of Dr. Pringle and given in his "Atlas of Dermatology." (Block kindly lent by Messrs. Rebman, the publishers of the work.)

Group IV.—Local Pigmentation of the Exposed Regions of the Skin, occurring as a Family Disease in Young Persons, and with tendency to Atrophy, Ulcerations, and finally to Cancerous Growths (Xeroderma pigmentosa).

Our portraits illustrating this remarkable disease are numerous, and permit the observer to trace all stages and gradations from what might be deemed merely very abundant freckles to great disfiguration by ulceration and the growth of fungating excrescences.

Nos. IX., X. and XI.—These portraits, taken from a paper by Professor Pick, of Prague, show the localisation of the pigment deposits and their abundance on the face and arms. As is usual several in the family were affected in a similar manner.

Portrait of Barbara, the eldest of those who suffered. This is the only portrait in our series in which the legs are shown to have suffered. The pigmentation involves apparently almost the whole surface, extending upon the trunk below the mammæ. It is severe on the legs and attended with vesication. There are ulcerations on various parts and growths from the lower eyelids and nose. It is stated that one of these was excised and did not return.

The portrait of Anna, aged 16, the second of Dr. Pick's series. The pigmentation is severe on face and hands. A growth from the gum as large as a walnut (epulis?) had been excised and had not returned.

Portrait of Joseph, third in the family. It will be seen that this portrait represents little more than what might be regarded as very extensive freckles. The face and backs of hands are the only parts affected.

It is a remarkable fact in Pick's series of cases that eleven children had been born in the family and that the three who suffered from xeroderma were all which had survived.

No. XII.—A portrait taken from Band xxxiv. of "Langenbuch's Archives." It shows the face, bust, and arms of a young man. The pigmentary condition scarcely amounts to more than severe freckles, but there is a malignant ulcer of considerable size in the middle of right cheek. The backs of hands and forearms are freckled.

Nos. XIII., XIV., XV.—Three portraits in one frame, showing the faces of two young lads, and the back of the hand of one of

them. They are from "Dr. Byrom Bramwell's Atlas" and represent Dr. Hunter's patients (see below).

No. XVI.—Portrait of a fair-complexioned boy in whom fungatory growths have occurred on several parts of the face.

No. XVII. and XVIII.—Two series of portraits from a family series published by Dr. Taylor, of New York.

No. XIX.—A portrait from "Dr. Pringle's Atlas of Selections from the St. Louis Hospital collection." This portrait is remarkable on account of the small amount of pigmentation which it exhibits, whilst, however, a cancerous ulcer has already formed on the nose. (See swing frame.)

No. XX.—Dr. Radcliffe Crocker's portrait of one of the family series which was the subject of his paper in the *Medico-Chirurgical Society's Transactions*. This series of cases was the first observed in England, and Dr. Crocker was the first to recognise that they belonged to the group already described by Kaposi in Vienna under the name of Xeroderma Pigmentosum. The portrait is that of a young girl, whose alæ nasi are destroyed by ulceration and her face extensively scarred. Near to one ear is a large fungating mass—epithelial cancer. Similiar but smaller ones are seen on other parts of the face.

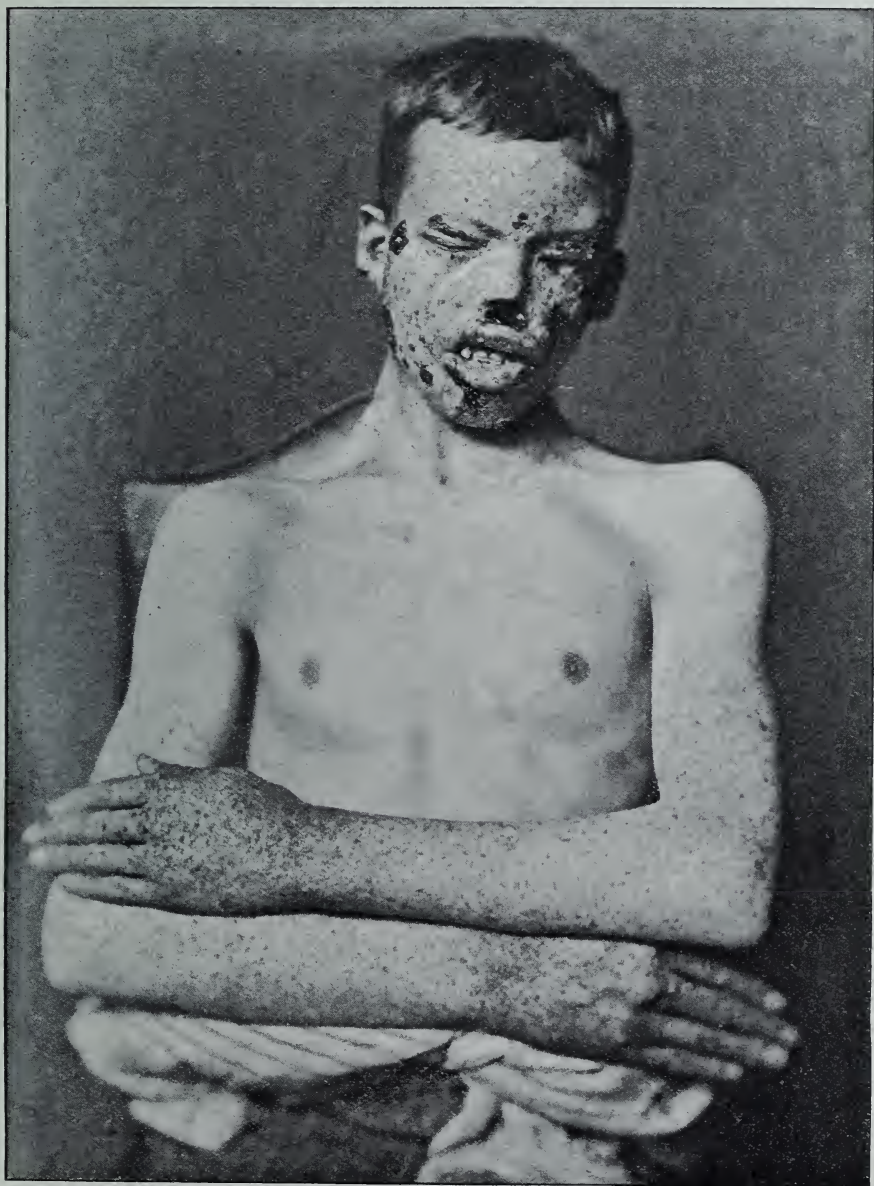
We are enabled, by Dr. Crocker's courtesy, to give portraits showing later conditions in two of his patients.

Nos. XXI. and XXII.—Two photographs presented by Dr. Radcliffe Crocker illustrating the later conditions in two of the patients who were the subjects of his paper. One of these represents the state of Benjamin Beddoes, at date May 1, 1890. The nose has been extensively destroyed and the face scarred and ulcerated. The pigmentation of the hands and arms is well seen. The second (here reproduced) is that of Alice Beddoes, and was taken January, 1896. This girl was the subject of the coloured portrait. A growth of epithelial cancer is seen on the chin, the alæ and tip of nose are destroyed, and the whole face involved in scars. Fungating growths had been excised from the ear and other parts and had not recurred.

In this portrait, as in her brother's, the restriction of the pigmentation to the exposed parts of the neck and upper chest is well shown.

No. XXIII.—A portrait of Dr. Colcott Fox's patient. The case is published in the *Illustrated Medical Times*.

No. XXIV.—In the same swing-frame with Dr. Calcott Fox's portrait are those of a girl who was under the care of M. Vidal, in



Portrait of Benjamin Beddoes, from a photograph presented by Dr. Radcliffe Crocker.



Paris. One of them shows the face, and the other the back of the neck. The morbid conditions of pigmentation, &c., are strictly limited to the exposed parts.

(To be continued.)

CORRESPONDENCE AND ANSWERS.

To the Editor of THE POLYCLINIC.

La Grange, N.C., U.S.A.,

November 20, 1900.

"Dear Sir,—

"I have read with much interest your editorial, 'Imperial Medicine,' in the November issue of THE POLYCLINIC, and beg to state that I heartily endorse every word it contains. It is absolutely necessary that the profession of medicine broaden and enlarge its views so as to take in the whole world, so to speak. Commercial intercourse is so far-reaching in the present day that unexplored countries and unknown diseases are brought to our very door, and it is essential that we understand these affections as well as the diseases which occur at home. I am pleased to note that the Polyclinic College has begun this work, and feel sure that it will be able to perform its part in a manner that will be highly pleasing.

"I remain, Sir, with great respects, yours truly,

"J. W. P. SMITHWICK, M.D."

* * *

THE ARSENICAL-BEER EPIDEMIC.—We may be sure that the unfortunate occurrence of arsenical poisoning on a large scale in Manchester and other places will not be allowed to pass without contributing its quota to medical knowledge. There has probably never been a better opportunity for observing the results of the administration of arsenic in excessive but not fatal doses. No doubt there have been many very slight cases, and probably a yet larger number of persons who have partaken of the beer yet never been ill. The cases must also have come under the observation of many different medical men. It is to be hoped that those who have had these opportunities will carefully record their experience. "Peripheral neuritis" is the condition which has as yet found the most prominent mention. It will be of interest to know whether it has always been non-symmetrical or general, and whether it has been attended by cerebral symptoms in any cases. We shall want to know also whether herpes zoster has been frequently observed. In a very interesting report given by Christison in his work on poisons many cases are mentioned in which only local paralysis occurred. It is since Christison's day that common zoster, a local form of neuritis, has been proved to be sometimes caused by arsenic. Other conditions, such as dark skin, keratosis of palms and soles, peritonitis, and cystitis, should also be looked for. There are yet another class of results which may possibly be encountered. It may chance that some persons who have only taken the medicated beer in small quantities may have been much the better for it. Probably no better form of administration could be devised if only the dosage were guaranteed. Arsenic is a remedy of very remarkable power in various directions, and it may possibly in this epidemic have cured many cases of neuralgia, asthenia, and general debility. It is also credited with efficiency in preventing catarrhal affections, and it is possible that it may have reduced the general mortality by preventing attacks of bronchitis and pneumonia during the recent damp weather. Thus even this dark cloud may have its silver lining. We note that it is stated that the gross mortality has been low in the districts most seriously affected.

DIARY FOR DECEMBER.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m.

| | | | |
|----|-----------|-----|---------------------------------------|
| 1 | Saturday | ... | |
| 2 | SUNDAY | ... | |
| 3 | Monday | ... | Cons. (Skin). Dr. A. Whitfield. |
| 4 | Tuesday | ... | Cons. (Med.). Dr. Guthrie Rankin. |
| 5 | Wednesday | ... | Clinical Lecture. Sir Hector Cameron. |
| 6 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 7 | Friday | ... | Cons. (Ear). Mr. R. Lake. |
| 8 | Saturday | ... | |
| 9 | SUNDAY | ... | |
| 10 | Monday | ... | Cons. (Skin). Mr. Malcolm Morris. |
| 11 | Tuesday | ... | Cons. (Med.). Dr. Harry Campbell. |
| 12 | Wednesday | ... | Cons. (Surg.). Mr. E. W. Roughton. |
| 13 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 14 | Friday | ... | Cons. (Eye). Mr. Treacher Collins. |
| 15 | Saturday | ... | |
| 16 | SUNDAY | ... | |
| 17 | Monday | ... | Cons. (Skin). Dr. Jas. Galloway. |
| 18 | Tuesday | ... | Cons. (Med.). Dr. C. T. Williams. |
| 19 | Wednesday | ... | Clinical Lecture. Dr. Burney Yeo. |
| 20 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 21 | Friday | ... | Cons. (Throat). Dr. Tilley. |
| 22 | Saturday | ... | |

The College will be closed during Christmas week.

OUR NEXT DINNER.

WE have delayed the printing of our last sheet in order to give to our members the gratifying information that the Right Hon. Arthur Balfour has kindly accepted the chairmanship of our Dinner, and has fixed the date for Wednesday, May 22. This welcome item of intelligence has just reached us through our Dean. It must now be the earnest endeavour of all our members and well-wishers to secure a long list of influential stewards.

EDITOR.

INDEX.

| | PAGE |
|--|------------------------|
| ABDOMEN, Diseases of | 20 |
| Addison's Disease | 17 |
| Ainos, Memoranda as to the | 265 |
| Alcoholic Heart | 32 |
| Angelioma, Infective | 110 |
| Aortic Regurgitation | 36 |
| Appendicitis | 313, 320 |
| Arthritis | 23, 237 |
| Asylums, Leper | 12 |
| Atlas of Skin Diseases | 170 |
| BACKHOUSE, JAMES | 11 |
| Balfour, Dr. George | 17 |
| Berry, Mr. James | 80 |
| Biceps, Myositis of | 347 |
| Black, Dr. Sinclair | 11 |
| Bladder, Tuberculosis of | 348 |
| Bloemfontein Hospitals | 109 |
| Boers | 14, 22, 31 |
| Bowles, Dr. | 36, 227, 275, 340, 345 |
| Bramwell, Dr. Byrom | 253 |
| Breast, Tumour in the | 240 |
| Bright's Disease | 33 |
| Bulawayo, Health conditions in | 205 |
| CACODYLIC Medication | 157, 220 |
| Cancer from Insolation | 367 |
| Cancer and the Microscope | 173 |
| Cantlie, Mr. | 293 |
| Cape of Good Hope Leprosy Commission | 46 |
| "Castel of Helth" | 137 |
| Catalogue-companion to the Museum | 301, 363 |
| Cerebro-spinal Meningitis | 19 |
| Childs, Dr., On Sewage Purification | 339 |
| Chinese and the Mongols | 266 |
| Chancre of the Meatus | 39 |
| Chorea | 34 |
| Circumcision | 5, 129 |
| Clinical Examination of the Blood | 300 |
| Clinical Memories | 15 |
| College Notes | 56, 121, 251, 297 |
| Collins, Mr. Treacher | 285 |
| Committees of Investigation | 63 |

| | PAGE |
|--|---------------|
| Congress notes | 172 |
| Consultation Cases : | |
| Bowles, Dr. R. L. | 32, 345 |
| Collins, Mr. Treacher | 285 |
| Ewart, Dr. William | 32, 113 |
| Goodhart, Dr. | 283 |
| Hutchinson, Mr. Jonathan | 39, 167, 238 |
| Lake, Mr. Richard | 43 |
| Morris, Mr. Malcolm | 352 |
| Rankin, Dr. Guthrie | 161 |
| Sharkey, Dr. | 283 |
| Taylor, Dr. Seymour | 234 |
| Thomson, Dr. StClair | 290 |
| DEFINITIONS of words and terms | 254 |
| Dermanyssus avium | 19 |
| Dermatitis, Exfoliative | 238 |
| Dislocation at Hip Joint | 242 |
| Drowning, Resuscitation from | 227, 275, 340 |
| Drugs and Articles of Diet | 64 |
| Dutch habits of Diet | 14 |
| ECZEMA | 42, 176 |
| Elbow-joint, Obscure injury of | 274 |
| Emphysema | 39, 221, 234 |
| Empyema | 113 |
| Epilepsy | 267 |
| Erysipelas and "The Rose" | 1 |
| Ewart, Dr. William: Treatment of Empyema | 113 |
| —— ——— Alcoholic Heart | 32 |
| —— ——— Chorea and its treatment | 34 |
| —— ——— "Cacodylic Medication" | 157, 220 |
| FALLACIES as to Syphilis | 132 |
| Faroe Islands | 135 |
| Fast-day Diet and Leprosy | 318 |
| Ferrier, Dr., on Epilepsy | 76 |
| Fijis, The | 261 |
| Flint, Austin | 16 |
| Frambœsia | 177 |
| Freckles | 365 |
| GAIRDNER, SIR WILLIAM | 15 |
| Gelatine Injections | 223 |
| Ginseng Plant, The | 309 |
| Goodhart, Dr. | 283 |
| Gowers, Sir W. R. | 267 |
| Gummata | 188 |
| HAIRY men | 264 |
| Hansen, Dr. Claus: On Tuberculosis | 139 |
| Hawthorne, Dr. : On Ocular Paralysis | 97 |
| Head symptoms in an Infant | 241 |
| Heart, Alcoholic | 32 |

| | PAGE |
|---|---|
| Hemiplegia in a Boy | 36 |
| Herpes Zoster | 240 |
| Hip Joint | 242 |
| Hospitals, Association of | 69 |
| — Reports, Publication of | 72 |
| House-building | 138 |
| Hutchinson, Mr. Jonathan : | |
| Cases from the Surgical Clinic | 39, 167, 238, 287, 352 |
| Chancre of the Meatus | 39 |
| Molluscum contagiosum following a scald | 40 |
| Symmetrically undescended testes | 41 |
| Generalised Vaccinia Eruption after Vaccination | 41 |
| Infective Angioma | 110 |
| Leprosy in the macular stage | 270 |
| The two forms of Purpura | 272 |
| | |
| ICHTHYOSIS | 60 |
| Imperial Medicine | 258 |
| Indurations in the Skin | 241 |
| Insolation Maladies | 363 |
| | |
| JACKSONIAN Epilepsy | 76 |
| Jacobson, Mr. W. H. A. | 320 |
| | |
| KAFIR Prejudice against Fish | 13 |
| Kaputine | 64 |
| Kohler, Dr. | 46 |
| | |
| LAKE, Mr. RICHARD : On Diseases of the Throat | 43 |
| Lamb, Mary ; Illness of | 197 |
| Laryngology | 290, 350 |
| Lentigo | 365 |
| Leprosy | 3, 10, 22, 46, 63, 74, 116, 139, 193, 243, 270, 301 |
| Leucodema in Addison's Disease | 17 |
| Livingstone, Doctor ; Experience of Leprosy | 22 |
| — — On Syphilis in Negroes | 138 |
| Lupus Vulgaris | 149 |
| | |
| MALARIA | 246 |
| Manchuria | 200 |
| Meatus, Chancre of | 39 |
| Medical Consultation Cases | 33, 113, 161, 234, 283 |
| Membership Fee, Equalisation of | 73 |
| Members, Non-resident | 67 |
| Menière's Disease | 173 |
| Meningitis | 19 |
| Microscope in Diagnosis of Cancer | 173 |
| Mitral Stenosis | 15 |
| Molluscum Contagiosum | 40, 62 |
| Mongols and Chinese | 266 |
| Morphea, Diffuse | 241 |
| Morris, Mr. Malcolm ; Consultation Cases | 352 |
| Morrow, Dr. ; On Leprosy | 10 |
| | |
| NASAL Discharges in Leprosy | 11 |

| | PAGE |
|--|-----------------|
| Nipple Cancer | 315 |
| Norway, Tuberculosis in | 139 |
| OCULAR Paralysis | 97 |
| Ophthalmic Cases.. .. . | 285 |
| Ord, Dr. William.. .. . | 23 |
| Osler, Professor | 56 |
| Œsophagus, Stricture of | 44 |
| Otology | 290 |
| PACHYDERMA Laryngis | 45 |
| Paget's Cancer of Nipple | 315 |
| Pancreatitis | 124, 140, 207 |
| Paralysis.. .. . | 43, 97 |
| Parasitic Insects | 118 |
| Paresis of Palate | 43 |
| Pinch, Captain | 300 |
| Plague, Its Signs and Symptoms | 293 |
| Plasmon | 64 |
| Polymorphous Eruptions | 190 |
| Portraits Illustrating Leprosy | 301 |
| Portugal | 139 |
| Pringle, Dr. J. J. | 149 |
| Phthisis in Mountain Races | 75 |
| —— — Wales | 75 |
| —— Pulmonary | 234 |
| Purpura, The two forms of.. .. . | 272 |
| RACIAL Tendency to Fatten | 265 |
| Rankin, Dr. Guthrie | 161 |
| References <i>versus</i> Testimonials | 7 |
| Regurgitation, Aortic | 36 |
| Renal Disease | 235 |
| Resuscitation from Drowning | 227, 275, 340 |
| Rheumatoid Arthritis | 237 |
| Robben Island | 11, 46, 47, 219 |
| Robson, Mr. A. W. Mayo | 140, 207 |
| Rose, Mr. William | 20 |
| SALINE Infusion | 224 |
| Sarcoma of Radius | 348 |
| Scabies, Portraits of | 62 |
| Sewage Purification | 339 |
| Sharkey, Dr. | 284 |
| Skin Diseases, Atlas of | 170 |
| Skin, Tuberculides of | 174 |
| Slavery and Boers | 22 |
| Smallpox.. .. . | 18 |
| Smith, Mr. Johnson; Consultation Cases | 347 |
| Steel, Dr. Graham | 33 |
| Stricture of the Œsophagus | 44 |
| Sun, Maladies caused by the | 363 |
| Syphilis | 133, 138 |
| TAYLOR, DR. SEYMOUR | 234 |

The Polyclinic

BEING THE JOURNAL OF THE

Medical Graduates' College London.

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION
OF THE MUSEUM AND LIBRARY COMMITTEE, BY

JONATHAN HUTCHINSON.

COMMITTEE OF CO-OPERATION.

T. CLIFFORD ALLBUTT.
ALFRED GALABIN.
STEPHEN MACKENZIE.
WM. MILLER ORD.

SIR WM. BROADBENT.
J. HUGHLINGS JACKSON.
MALCOLM MORRIS.
C. THEODORE WILLIAMS.

CONTENTS.

| | PAGE |
|--|------|
| ERYSIPELAS AND "THE ROSE" | 1 |
| THE DANGERS OF CIRCUMCISION | 5 |
| REFERENCES <i>versus</i> TESTIMONIALS | 7 |
| DR. MORROW ON LEPROSY | 10 |
| NASAL DISCHARGES IN LEPROSY | 11 |
| LEPER ASYLUMS REALLY PRISONS | 12 |
| THE FISH TRADE IN NATAL | 13 |
| DRIED FISH IN CAPE COLONY | 13 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| CLINICAL MEMORIES: | |
| SIR WILLIAM T. GAIRDNER, K.C.B.... | 15 |
| ON THE IMPORTANCE OF EARLY DIAGNOSIS AND TREATMENT IN SURGICAL DISEASES OF THE ABDOMEN: | |
| WILLIAM ROSE, B.S., F.R.C.S. | 20 |
| THE CLINICAL RELATIONS OF ARTHRITIS: | |
| WILLIAM M. ORD, M.D., F.R.C.P. | 23 |
| NOTES OF CASES DEMONSTRATED IN CONSULTATIONS: | |
| MEDICAL CASES: DR. WILLIAM EWART, DR. R. L. BOWLES | 32 |
| CASES WITH COMMENTS FROM THE SURGICAL CLINIC: J. HUTCHINSON ... | 39 |
| DISEASES OF THE THROAT: RICHARD LAKE | 43 |
| REVIEWS AND NOTICES OF BOOKS... .. | 46 |
| COLLEGE NOTES, BY THE DEAN | 56 |
| MUSEUM NOTES, WITH ILLUSTRATION | 60 |
| COMMITTEES OF INVESTIGATION | 63 |
| NEW DRUGS AND ARTICLES OF DIET | 64 |
| CORRESPONDENCE AND ANSWERS | 65 |

Published by

JOHN BALE, SONS & DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, LONDON, W.

Price : One Shilling.



TRADE
MARK

‘Tabloid’ BRAND

Medicine Cases.



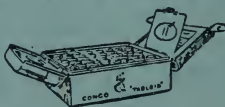
ALL IMPORTANT EXPEDITIONS of recent years have been equipped with ‘Tabloid’ Medicine Chests or Cases fitted with ‘Tabloid’ Drugs.

These outfits have therefore, been subjected to the most trying conditions of climate and usage but the medical officers in charge have invariably been able to testify to the portability, convenience, lightness, strength, and completeness of the equipments, and to the lasting activity and solubility of the ‘Tabloid’ Drugs. In his official government report the Chief Medical Officer of the last British Military Expedition to Ashanti says — “The ‘Tabloid’ Medicines were found to be most convenient and of excellent quality . . . The quality of the medicines was so good that no other should be taken into the field.”

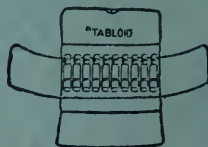
A FULLY ILLUSTRATED LIST WITH PARTICULARS OF CASES SUITABLE FOR USE IN HOME PRACTICE OR ABROAD WILL BE SENT ON REQUEST.



No. 20. ‘TABLOID’ CARRIAGE CASE.



CONGO ‘TABLOID’ MEDICINE CHEST.



No. 15. ‘TABLOID’ POCKET CASE.

Burroughs Wellcome and Co., London and Sydney.

Advantages offered by the

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC

to its Members—Non-Resident as well as Resident.

In the belief that the advantages offered by the Polyclinic to Medical Men residing at a distance from London are not sufficiently known, the subjoined statement has been prepared.

I. They can at any time send up or bring patients for consultation (on the understanding that the case is one suitable for gratuitous advice).

II. They can attend all Consultations and Clinical Lectures. The Consultations take place from 4 to 5 every afternoon except Saturday and the Clinical Lectures usually at 5 o'clock.

III. They have access at all suitable hours to the Library, the Reading Room and the Clinical Museum.

IV. They receive the Journal. It is published monthly and contains, with much other Clinical Matter, a Record of the Lectures and of the more important Consultation Cases and a "Companion-Catalogue to the Museum."

V. They have access under certain conditions to the Pathological Laboratory and can also obtain analyses and examinations of specimens.

The Subscription which secures the above privileges
is One Guinea a year.

DONATION FORM.

I have pleasure in enclosing a Donation to the funds of the "Polyclinic," and desire that it be devoted to the objects which I have designated.

- I.—THE GENERAL OBJECTS OF THE INSTITUTION.
- II.—THE JOURNAL.
- III.—THE COMMITTEES OF INVESTIGATION.
- IV.—THE BENEFIT OF PATIENTS IN THE CONSULTATION ROOMS.
- V.—THE PROMOTION OF MEDICAL OBJECTS IN CONNECTION WITH MISSIONS.

Name

Address

APPLICATION FOR MEMBERSHIP.

Date

To THE DEAN OF THE
MEDICAL GRADUATES' COLLEGE AND POLYCLINIC,
22, CHENIES STREET, W.C.

Dear Sir,

I desire to become a Member of the Medical Graduates' College and Polyclinic, and beg to enclose a cheque for One Guinea as my subscription for the current year.

Name

Qualification

Address

Subscription to Journal Order Form.

To THE PUBLISHERS OF THE "POLYCLINIC,"
MESSRS. JOHN BALE, SONS AND DANIELSSON, LTD.,
83-89, GT. TITCHFIELD STREET, LONDON, W.

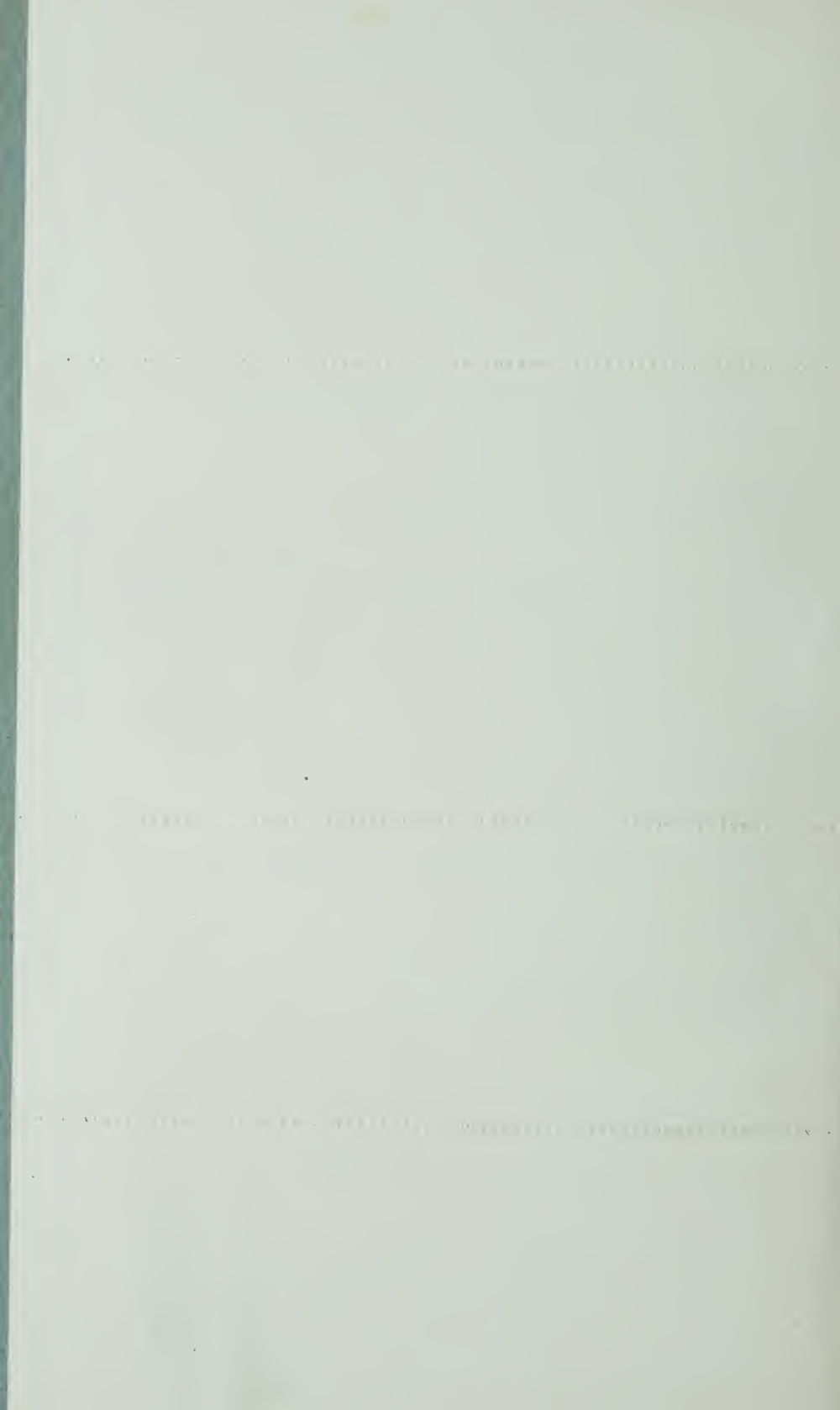
Please forward to me to the undermentioned address the "Polyclinic Journal" for the current year. I enclose Postal Order for Twelve Shillings and Sixpence.

Name

Address

FORM OF BEQUEST.

*I hereby bequeath to the "Medical Graduates' College and Polyclinic,"
Chenies Street, London, the sum of _____ pounds, to be paid
out of such portion of my estate as is available for such purpose.*



THE CENTENARY OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

NOTICE.—In view of the Celebration of the Centenary of the Royal College of Surgeons

THE PRACTITIONER

For JULY

contains Special Articles on the COLLEGE and the HUNTERIAN MUSEUM, together with new and valuable Portraits of JOHN HUNTER, WILLIAM CLIFT, RICHARD OWEN, and a new Portrait of the present President, Sir WILLIAM MACCORMAC.

OTHER CONTENTS OF THIS NUMBER.

THE MONTH:—

The Centenary of the College of Surgeons.
The History of the College.
The Hunterian Museum.
The Endowment of Medicine.
Laboratories Past and Present.
Medicine not Mendicant.

A Striking Contrast.
The Duty of Millionaires towards Medicine.
Epsom College.
The Golden Rule of Medical Life.
A Hypnotised Jury.
"Truth" *versus* Fraud.

HEROES OF MEDICINE:—

John Hunter. With Portrait.

ORIGINAL COMMUNICATIONS:—

Diabetes Mellitus. By ROBERT SAUNDBY, M.D., LL.D., F.R.C.P.
On the Cause of Diabetes Mellitus. By R. T. WILLIAMSON, M.D.Lond., F.R.C.P.

PUBLIC HEALTH:—

Epidemiology in Relation to Public Health.

A REVIEW OF THE MEDICAL SCIENCES:—

General Surgery. By ALBERT CARLESS, M.S.Lond., F.R.C.S. Illustrated.
Diseases of the Nervous System. By J. S. RISIEN RUSSELL, M.D., F.R.C.P. Illustrated.
Diseases of the Upper-Air Passages. By STCLAIR THOMSON, M.D., M.R.C.P. Lond., F.R.C.S.Eng.

REVIEWS OF BOOKS.

LITERARY GOSSIP.

PRACTICAL NOTES.

A MEDICAL CALENDAR.

THE PRACTITIONER. Edited by MALCOLM MORRIS.

Annual Subscription, 21s., post free.

Single Copies, 2s. each, can be obtained from any Bookseller.

CASELL & Co., Ltd., London, Paris, New York & Melbourne.

J. H. MONTAGUE,

SURGICAL INSTRUMENT MAKER AND CUTLER.

By Appointment to—
The Honourable Council of
India,
St. George's Hospital,
Westminster Hospital, &c.

TELEGRAPHIC ADDRESS—
"MASTOID, LONDON."



PATENT VACCINE EXPELLER.

Price 1/6 each,
or, 16/- per doz.

To meet the requirements
of the
Local Government Board.

Can be thoroughly
Sterilised.

PATENT ATMO-THERME STERILISER,

Made in Tin, 14 by 8 Price, £2 10 0

„ Copper, N.P., 14 by 8 „ £5 5 0

Any size made to order

CARTER BRAINE'S IMPROVED ORMSBY'S INHALER,

With Attachment for the Administration of A. C. E. Mixture and Chloroform,

Price Complete, Nickel Plated £3 3 0

COMPLETE OUTFITS for the PRODUCTION of RONTGEN'S "X" RAYS.

Skiagraphs Taken at any Time, or by Appointment.

101, NEW BOND STREET, LONDON, W.

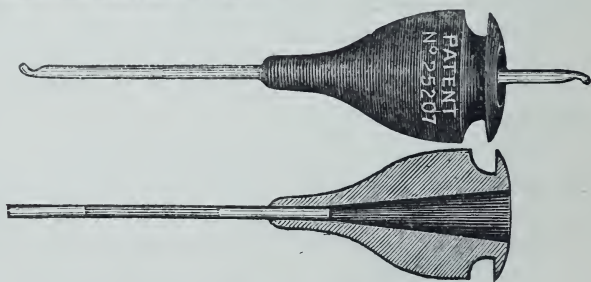
FLUX'S CHLOROFORM INHALER.

For the safe
administration
of Chloroform.

Vide the *Lancet*, Feb. 3rd, 1900.

Price, complete in Case,

£1 15 0



DIARY FOR JULY.

 APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m.

| | | | |
|----|-----------|-----|---|
| 1 | SUNDAY | ... | |
| 2 | Monday | ... | Cons. (Skin). Dr. Jas. Galloway. |
| 3 | Tuesday | ... | Cons. (Med.). Dr. J. F. Payne. |
| 4 | Wednesday | ... | Conversazione, 8. Lecture by Prof. Osler. |
| 5 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 6 | Friday | ... | Cons. (Eye). Mr. Treacher Collins. |
| 7 | Saturday | ... | |
| 8 | SUNDAY | ... | |
| 9 | Monday | ... | Cons. (Skin). Dr. Colcott Fox. |
| 10 | Tuesday | ... | Cons. (Med.). Dr. W. B. Cheadle. |
| 11 | Wednesday | ... | Cons. (Med.). Dr. Hillier. Leprosy Committee, 5.30. |
| 12 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 13 | Friday | ... | Cons. (Nose and Throat). Dr. Tilley. |
| 14 | Saturday | ... | |
| 15 | SUNDAY | ... | |
| 16 | Monday | ... | Cons. (Skin). Mr. Malcolm Morris. |
| 17 | Tuesday | ... | Cons. (Med.). Dr. Miller Ord. |
| 18 | Wednesday | ... | Clinical Lecture. Mr. Mayo Robson. |
| 19 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 20 | Friday | ... | Cons. (Ear). Mr. R. Lake. |
| 21 | Saturday | ... | |
| 22 | SUNDAY | ... | |
| 23 | Monday | ... | Cons. (Skin). Dr. A. Whitfield. |
| 24 | Tuesday | ... | Cons. (Med.). Dr. J. E. Squire. |
| 25 | Wednesday | ... | Cons. (Med.). Dr. Guthrie Rankin. |
| 26 | Thursday | ... | Cons. (Surg.). Mr. Hutchinson. |
| 27 | Friday | ... | Cons. (Eye). Mr. Marcus Gunn. |
| 28 | Saturday | ... | |
| 29 | SUNDAY | ... | |
| 30 | Monday | ... | |
| 31 | Tuesday | ... | |

DIARY FOR JULY.

APPOINTMENTS AT OTHER INSTITUTIONS, SOCIETIES, &c.

| | | | |
|----|-----------|-----|---|
| 1 | SUNDAY | ... | |
| 2 | Monday | ... | |
| 3 | Tuesday | ... | |
| 4 | Wednesday | ... | Obstetrical Society : 20, Hanover Square, 8. |
| 5 | Thursday | ... | |
| 6 | Friday | ... | Ophthalmological Society : 11, Chandos Street, 8. |
| 7 | Saturday | ... | |
| 8 | SUNDAY | ... | |
| 9 | Monday | ... | |
| 10 | Tuesday | ... | |
| 11 | Wednesday | ... | |
| 12 | Thursday | ... | Gynæcological Society : 20, Hanover Square 8. |
| 13 | Friday | ... | |
| 14 | Saturday | ... | |
| 15 | SUNDAY | ... | |
| 16 | Monday | ... | |
| 17 | Tuesday | ... | |
| 18 | Wednesday | ... | |
| 19 | Thursday | ... | |
| 20 | Friday | ... | |
| 21 | Saturday | ... | |
| 22 | SUNDAY | ... | |
| 23 | Monday | ... | |
| 24 | Tuesday | ... | |
| 25 | Wednesday | ... | |
| 26 | Thursday | ... | |
| 27 | Friday | ... | |
| 28 | Saturday | ... | |
| 29 | SUNDAY | ... | |
| 30 | Monday | ... | |
| 31 | Tuesday | ... | |

By Her Majesty's



Royal Letters Patent.

"GLOBENARIS" WATER (A SPARKLING TABLE WATER.)

Distilled Water aerated with Oxygen and Carbonic Acid Gases by C. & Co.'s Patent Process.

ANALYTICAL REPORT by Sir E. FRANKLAND, K.C.B., D.C.L., F.R.S., late Analyst to the Local Government Board.

"The sample of Distilled Water from Messrs. Cooper & Co.'s Mineral Water Factory, contains no trace of organic matter, and is quite free from microbes or their spores.—(Signed) E. FRANKLAND."

N.B.—The head of this Syphon is porcelain-lined, thus ensuring absolute freedom from metallic contamination.

Messrs. C. & Co.'s are the only Waters aerated with Oxygen and Carbonic Acid Gases.

COOPER & CO.'S LIQ. QUININÆ SALICYLATIS. Contains one grain of natural Salicylate of Quinine in each fluid drachm. It has given admirable results in the treatment of CHRONIC and ATONIC forms of GOUT, RHEUMATISM, and INFLUENZA.

In 4, 8, 16, and 40-oz. Bottles.

COOPER & CO.'S "GLOBENA" MEAT ESSENCES.

"GLOBENA" Beef Essence.

"GLOBENA" Chicken Essence.

"GLOBENA" Mutton Essence.

"GLOBENA" Turtle Essence.

These Essences consist solely of the juice of the Finest Meats, without the addition of water or any other substance. Supplied in Glass Jars.

"Globena" Pure Beef Tea (concentrated).

"Globena" Meat Juice. The pure concentrated juice of the Finest Beef, thereby more nearly representing Fresh Meat than any Extract of Meat or similar preparation.

"Globena" Meat Lozenges. A concentrated meat Lozenge of delicate flavour, furnishing in the smallest possible bulk the maximum of nourishing and easily digestible food.

"Globena" Beef and Malt Wine. A nutritious and strengthening Tonic Wine.

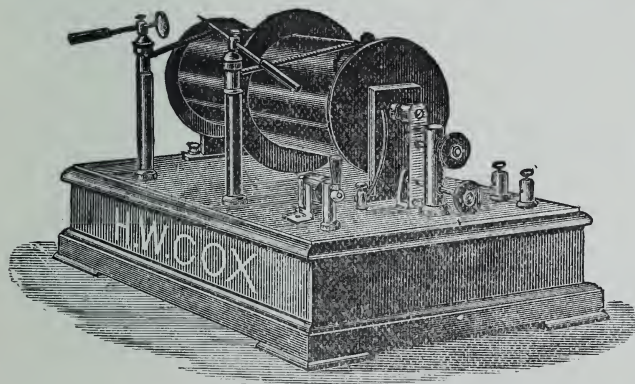
COOPER & CO., Manufacturing Pharmaceutical Chemists, 80, GLOUCESTER ROAD, SOUTH KENSINGTON, S.W.

Steam Laboratories—8 & 9, STATION BUILDINGS (adjoining the Gloucester Rd. Station).
Telephone—340, KENSINGTON. Telegrams—"SINAPINE, LONDON."

X - RAYS APPARATUS

Of the Highest Quality and Finish only.

BUY DIRECT FROM THE MAKERS.



As supplied by us to H.M. Government for use in South Africa, The "Princess of Wales" Hospital Ship, Scottish National Red Cross Hospital, The Welsh Hospital, The Yeomanry Hospital, Medical Men, Hospitals, Chemists, and X-Ray Workers in all parts of the World. Our Apparatus gives the very best results, and we guarantee all our coils against breaking down.

Our price list, with simple instructions how to set about work, will be sent post free to readers of the "Polyclinic."

HARRY W. COX, Ltd.,

Manufacturing Electricians,

10, 11, and 28, CURSITOR STREET, CHANCERY LANE, W.C.

SPECIAL DARK ROOM FOR DEMONSTRATIONS.

Concise yet comprehensive summaries of all in periodical literature important to the practitioner. Facts, not mere opinions, characterise the "Review," instead of the commonplace remarks and indiscriminate and useless notices of crude and unproved views which constitute many so called "Epitomes."

The Medical Review

(MEDICAL AND SURGICAL REVIEW OF REVIEWS.)

AN INDEXED AND ILLUSTRATED
MONTHLY RECORD OF ALL THAT IS IMPORTANT TO THE PRACTITIONER IN THE
MEDICAL PERIODICALS IN THE WORLD.

PRINTED IN LARGE CLEAR TYPE, ON SUPERFINE PAPER.

Subscription £1 per annum, post free to any part of the world.

By the suppression of all unessential matter, a paper written with any definite object—and such alone is valuable—can generally be compressed into a comparatively brief report, and yet remain a clear and readable account of the subject, so that nothing of importance is lost, and often, in lucidity, much is gained. Merely to mention a few of the leading features of an article serves no useful purpose.

"... A great boon to the profession all over the world. . . I applaud not only your scheme, but the manner of its execution. . ."—JONATHAN HUTCHINSON, LL.D., F.R.S., Ex-President of the Royal College of Surgeons, England.

"Extremely useful to the busy practitioner."—*Lancet*.

"... I think you are about to fill a very great want. . ."—T. CLIFFORD ALLBUTT, M.A., M.D., F.R.C.P., F.R.S., Regius Prof. of Physic, Cambridge University.

"... It would be impossible for such a journal not to take at once a first place. . ."—*Birmingham Medical Review*.

"... Of great value to the general practitioner, and to teachers and authors. . . ."—BYROM BRAMWELL, M.D., F.R.C.P., Edin.

"Destined to the greatest and legitimate success. . . Well edited. Giving an exact account of all of importance in science and medical practice."—*Journal des Practiciens*.

"... The 'Review' brings me into touch with methods and ideas which I could not possibly have otherwise obtained. . . No surgeon can afford to do without such an excellent index to scientific progress."—J. O'CONOR, M.A., M.D., Senior Medical Officer, British Hospital, Buenos Ayres.

IMPORTANT TO NEW SUBSCRIBERS.

BACK NUMBERS.

The attention of New Subscribers is called to the desirability of applying for Vols. I. and II. of the "REVIEW" before they are out of print.

As the important facts recorded in the "REVIEW" are not presented as isolated contributions only, but as collated records, the bound volumes present, in a unique manner, the definite progress of medical science, and render all that is important to the practitioner in the current medical periodicals readily accessible.

Already one of the parts has had to be reprinted, and now only a limited number of Vol. II. is available for new subscribers. The first 500 new subscribers to the "REVIEW" for this current year, who purchase Vol. II. will each be entitled to a bound copy of Vol. I. (Nos. 1, 2, and 3) free of charge.

The price for Vol. II., crown 4to, cloth, is 21/- net.

All communications to be addressed to the SECRETARY, Cheques and Postal Orders should be made payable to THE MEDICAL AND SURGICAL "REVIEW OF REVIEWS," LIMITED, 12, Norfolk Street, Strand, London, W.C., and crossed "BROWN, JANSON & Co."

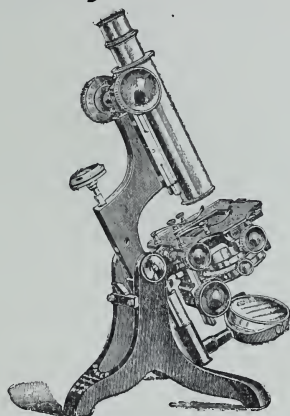
BACTERIOLOGY.

C. BAKER, Manufacturers & Agents.

All Apparatus
necessary for
research

Microscopes
(English and
Continental).

Catalogues Post Free
to readers of this
Journal, apply—



Microtomes.

Stains.
(Grubler's)

Hæmometers.

Polarimeters.

Centrifuges.

Incubators.

Sterilisers.

244, HIGH HOLBORN, W.C.

BLOOD EXAMINATION.

The Electrical Standardizing, Testing and Training Institution.

Principal:

HUGH ERAT HARRISON, B.Sc., M.I.E.E.

Gentlemen's Sons Prepared for the **ELECTRICAL ENGINEERING PROFESSION.**

The training is thoroughly theoretical and practical, the Institution being associated with most of the leading Electrical Firms and Central Electric Lighting Stations, for the express purpose of affording its Students a proper practical insight into their future profession. Prospectus on application to the Secretary.

INSPECTING AND TESTING DEPARTMENT.

The Institution undertakes the inspection and test of electrical plant, and certifies the same either on behalf of Manufacturers or Buyers. Private testing rooms, supplied with current and apparatus, are let to Experimenters. Terms on application to the Secretary.

FARADAY HOUSE,
CHARING CROSS ROAD, LONDON, W.C.

Telegraphic Address:—"STANDARDIZING, LONDON."

THE
NEW SYDENHAM SOCIETY.

President—HENRY POWER, Esq., F.R.C.S.
Treasurer—W. SEDGWICK SAUNDERS, M.D., F.S.A.
Hon. Sec.—JONATHAN HUTCHINSON, Esq., F.R.S.

ANNUAL SUBSCRIPTION—ONE GUINEA.

THE LEXICON OF MEDICAL TERMS

Is now complete in Five Volumes. APPENDICES are in preparation.

The complete work (25 parts) can be obtained for £2 10s.; bound in 5 vols., roan back, marbled edges, £3 3s.; or in half morocco, cloth sides, gilt tops, £3 13s. 6d.

The First Volume of the Society's

ATLAS OF PATHOLOGY

Is now complete, and can be had bound in cloth, with Index,

Price £3 3s. 0d.

The Thirteenth Fasciculus of this Atlas will be ready shortly, and will contain

ILLUSTRATIONS OF GOUT & RHEUMATIC GOUT.

The following works are in the printer's hands:

A VOLUME OF SELECTED LECTURES AND PAPERS FROM FOREIGN SOURCES. This Volume will contain, with others,

Lectures on the following subjects:

Erb on the Etiology of Tabes.
Erb on the Treatment of Tabes.
Fournier on Recurring Syphilitic Eruptions.
Ziemssen on the Open-air Treatment of Phthisis.

Ehlers on Statistics of Tertiary Syphilis.
Nielsen on Melanosis and Keratosis Arsenicalis.
Jadassohn on the Dermatoses produced by Drugs.

FUNDAMENTAL DATA OF MODERN PATHOLOGY. BY PROFESSOR MONTI.

THE PATHOLOGY OF THE BLOOD. BY PROFESSOR LIMBECH.

A VOLUME OF SELECTED PAPERS BY ENGLISH AUTHORS.

This Volume will comprise, with others:—

Several Papers on Gynecological subjects, by the late Dr. Braxton Hicks, with a portrait of the Author.

Some Papers by the late Sir G. M. Humphry, with a portrait.

The Original Paper "On Certain Diseases of the Lymphatic Glands," by the late Dr. Hodgkin, with a portrait.

* * Subscriptions for the current year became due in January, and if not already paid should be at once forwarded to the Society's agent. The issue of books for the year commences in June.

Those wishing to join the Society should communicate direct with the Hon. Secretary, Mr. JONATHAN HUTCHINSON, 15, Cavendish Square, London, W., or the Society's Agent, from whom copies of the Annual Report containing full particulars may be obtained.

Mr. LEWIS, Agent, 136, Gower Street, London, W.C.

Jas. Swift & Son,

MANUFACTURING OPTICIANS,

Solely appointed to the Army Medical Department, War Office, for the supply of Microscopes.

Patent 4-legged Microscope, with Coarse and Fine Adjustment, Large Stage suitable for Bacteriological work, Flat and Concave Mirrors, $\frac{3}{4}$ & $\frac{1}{2}$ Objectives (first quality), one Ocular and Iris Diaphragm. The whole packed in Mahogany Cabinet,

£7 0 0

SPECIAL MICROSCOPES FOR BACTERIOLOGISTS.

Prospectus Free on Application.

81, TOTTENHAM COURT ROAD, W.

Now Ready. Medium 8vo. Cloth lettered. 15s. net. Post Free 16s.



A HANDBOOK OF THE

GNATS OR MOSQUITOES.

MAINLY intended for the Use of Students of Tropical Medicine giving the Anatomy and Life History of the Culicidæ, with Tables and a Compilation of the descriptions of over 240 species, and Illustrated with one folding and seven full-page plates, and numerous figures in the text.

By **MAJOR GEO. M. GILES, I.M.S., M.B.Lond., F.R.C.S.,**

Formerly Naturalist to the Indian Marine Survey.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Gt. Titchfield Street, W.

PERSONS desiring to communicate with **THE LONDON SCHOOL OF TROPICAL MEDICINE** should address The Medical Tutor, London School of Tropical Medicine, Seamen's Hospital, Royal Albert Dock, E., or The Secretary, P. Michelli, Esq., Seamen's Hospital, Greenwich, S.E.

THE JOURNAL OF TROPICAL MEDICINE.

A MONTHLY JOURNAL DEVOTED TO MEDICAL, SURGICAL AND GYNÆCOLOGICAL WORK IN THE TROPICS.

Edited by **James Cantlie, M.B., F.R.C.S.,** and **W. J. Simpson, M.D., F.R.C.P.**

Published by **JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield St., London, W.**

Subscription, 17/- per annum, payable in advance.

With Illustrations, 808 pages, crown 8vo, 12s. 6d.

AN INDEX OF MEDICINE:

A Manual for the Use of Senior Students and Others,

BY

SEYMOUR TAYLOR, M.D., F.R.C.P.,

Physician to the West London Hospital.

PRESS OPINIONS.

The Lancet.—"Dr. Seymour Taylor may certainly be congratulated on the success of his labours. He has produced exactly what he desired, and the book may confidently be recommended to those for whom it is intended."

The British Medical Journal.—"As a supplement to the larger standard treatises, and so as a means of codifying the knowledge of the more advanced, it will prove invaluable."

London: **SMITH, ELDER & CO.**

THE MEDICAL GRADUATES' COLLEGE & POLYCLINIC

22, CHENIES STREET, LONDON, W.C.



Vice-Patrons:

THE LORD IVEAGH, K.P., LL.D.
THE RIGHT HON. LORD STRATHCONA AND MOUNT ROYAL, G.C.M.G.
THE RIGHT HON. A. J. BALFOUR, M.P., LL.D.
THE RIGHT HON. LORD AVEBURY, F.R.S.

President:

Sir Wm. H. Broadbent, Bart., LL.D., F.R.S.

Vice-President:

Prof. Clifford Allbutt, LL.D., F.R.S.
Sir John Banks, K.C.B., M.D.
Sir James Crichton Browne, LL.D., F.R.S., M.D.
Thomas Bryant, F.R.C.S.
Sir Joseph Fayrer, K.C.S.I., M.D., F.R.S.
Sir Wm. T. Gairdner, K.C.B., LL.D., M.D.
Jonathan Hutchinson, LL.D., F.R.S.

J. Hughlings Jackson, LL.D., F.R.S.
J. Fletcher Little, M.B., M.R.C.P.
Col. Kenneth McLeod, LL.D., M.D.
Sir John Watt Reid, K.C.B., LL.D., M.D.
Sir John Burdon Sanderson, Bart., LL.D., F.R.S.
Sir John Batty Tuke, M.P., M.D.
Sir Samuel Wilks, Bart., LL.D., F.R.S.

Treasurer: Chas. Theodore Williams, M.D., F.R.C.P.

Dean: Guthrie Rankin, M.D., M.R.C.P.

Council:

Chairman: Jonathan Hutchinson, LL.D., F.R.S.

Vice-Chairman: Malcolm A. Morris, F.R.C.S.

James Berry, B.S., F.R.C.S.
Robt. Bowles, M.D., F.R.C.P.
James Cantlie, B.S., F.R.C.S.
Prof. Crookshank, M.B.
Alderman Crosby, M.D., F.R.C.S.
Alfred L. Galabin, M.D., F.R.C.P.
James F. Goodhart, M.D., F.R.C.P.

Alfred P. Hillier, M.D.
Constantine Holman, M.D.
Boyd Joll, M.B.
Sir William Kynsey, F.R.C.P.
Stephen Mackenzie M.D., F.R.C.P.
Patrick Manson, LL.D., M.D.

George Oliver, M.D., F.R.C.P.
W. Miller Ord, M.D., F.R.C.P.
Solomon Smith, M.D., M.R.C.P.
James Taylor, M.D., F.R.C.P.
Seymour Taylor, M.D., F.R.C.P.
StClair Thomson, M.D., F.R.C.S.

Medical Superintendent:

A. E. Hayward Pinch, F.R.C.S.

The Polyclinic

BEING THE JOURNAL OF THE

Medical Graduates' College London.

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION
OF THE MUSEUM AND LIBRARY COMMITTEE, BY

JONATHAN HUTCHINSON.

COMMITTEE OF CO-OPERATION.

T. CLIFFORD ALLBUTT.
ALFRED GALABIN.
STEPHEN MACKENZIE.
WM. MILLER ORD.

SIR WM. BROADBENT.
J. HUGHLINGS JACKSON.
MALCOLM MORRIS.
C. THEODORE WILLIAMS.

CONTENTS.

| | PAGE |
|--|------|
| OUR NON-RESIDENT MEMBERS | 67 |
| ASSOCIATION OF HOSPITALS... .. | 69 |
| ASSOCIATED PUBLICATION OF HOSPITAL REPORTS | 72 |
| EQUALISATION OF OUR MEMBERSHIP FEE | 73 |
| PROPOSED SOLUTION OF THE LEPROSY PROBLEM | 74 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| ABSTRACT OF A LECTURE ON JACKSONIAN EPILEPSY: | |
| DAVID FERRIER, M.D., LL.D., F.R.S. | 76 |
| ON THE DIAGNOSIS AND OPERATIVE TREATMENT OF THYROID ADENOMATA: | |
| JAMES BERRY, B.S., F.R.C.S. | 80 |
| ON THREE CASES OF OCULAR PARALYSIS: | |
| C. O. HAWTHORNE, M.D., M.R.C.P. | 97 |
| ON INFECTIVE ANGEIOMA IN ASSOCIATION WITH TUBERCULOSIS: | |
| JONATHAN HUTCHINSON, F.R.S., LL.D. | 110 |
| NOTES OF CASES DEMONSTRATED IN CONSULTATIONS: | |
| MEDICAL CASES: DR. WILLIAM EWART | 113 |
| REVIEWS AND NOTICES OF BOOKS... .. | 116 |
| MUSEUM NOTES | 118 |
| COLLEGE NOTES, BY THE DEAN | 121 |
| CORRESPONDENCE AND ANSWERS | 126 |

Published by
JOHN BALE, SONS & DANIELSSON, LTD.
OXFORD HOUSE,
83-89, GREAT TITCHFIELD STREET, OXFORD STREET, LONDON, W.

Price : One Shilling.



'Kepler'

Malt Extract

is made from the finest selected winter-malted barley only. No inferior or mixed cereals are used. It is rich in nutritive, tonic and digestive constituents, and is of exceptional palatability.

The British Medical Journal reports:—

"We can recommend the 'Kepler' Extract of Malt. Its qualities are not deteriorated nor its flavour spoiled."

Supplied in small and large bottles.



BURROUGHS WELLCOME AND CO.,
LONDON and SYDNEY.

[1897-1901]

THE PRACTITIONER.

A JOURNAL OF PRACTICAL MEDICINE.

EDITED BY

MALCOLM MORRIS.

The AUGUST PART, Price 2/-, contains:—

THE MONTH:—

The Hospital Breakdown in
South Africa.
A Prophecy Fulfilled.
The Infinitesimal Dilution of
Statistics.

"Simple Continued Fever."
" 'Bobs' a Homœopath."
The Record of a Noble Life.
The Revolution in the B.M.A.

ORIGINAL COMMUNICATIONS:—

Recent Experimental Contributions to the Pathology of Diabetes. By John
Rose Bradford, M.D., D.Sc., F.R.C.P., F.R.S.
Glycosuria and Diabetes in relation to Life Assurance. By Hector
Mackenzie, M.D., F.R.C.P.
Clinical Tests for Sugar in the Urine. By R. T. Williamson, M.D.Lond.,
F.R.C.P.
Some Points in the Present Day Treatment of Diabetes.
Heredity and Immunity. By G. Archdall Reid, M.B., F.R.S.Edin.

HEROES OF MEDICINE:—

Thomas Willis. (*With Portrait.*)

A MEDICO-LITERARY CAUSERIE:—

Poisons and Poisoners: Old and New.

PARIS LETTER:—

Anæsthesia by Injection of Cocaine into the Sub-arachnoid Space in the
Lombar Region.

PUBLIC HEALTH:—

Hospital Administration in relation to the Aerial Convection of Small-pox.

A REVIEW OF THE MEDICAL SCIENCES:—

Diseases of the Digestive Organs. By H. D. Rolleston, M.A., M.D., F.R.C.P.
(*Illustrated.*)
Ophthalmology. By E. Treacher Collins, F.R.C.S.
Infectious Fevers. By Claude B. Ker, M.D., M.R.C.P.Edin.

REVIEWS OF BOOKS. (*Illustrated.*) LITERARY GOSSIP.

NOVELTIES AND NEW INVENTIONS.

PRACTICAL NOTES. A MEDICAL CALENDAR.

Annual Subscription, 21s., post free.

CASSELL & Co., Ltd., London, Paris, New York & Melbourne.

THE MEDICAL GRADUATES' COLLEGE & POLYCLINIC

22, CHENIES STREET, LONDON, W.C.



Vice-Patrons:

THE LORD IVEAGH, K.P., LL.D.
THE RIGHT HON. LORD STRATHCONA AND MOUNT ROYAL, G.C.M.G.
THE RIGHT HON. A. J. BALFOUR, M.P., LL.D.
THE RIGHT HON. LORD AVEBURY, F.R.S.

President:

Sir Wm H. Broadbent, Bart., LL.D., F.R.S.

Vice-President:

Prof. Clifford Allbutt, LL.D., F.R.S.
Sir John Banks, K.C.B., M.D.
Sir James Crichton Browne, LL.D., F.R.S., M.D.
Thomas Bryant, F.R.C.S.
Sir Joseph Fayrer, K.C.S.I., M.D., F.R.S.
Sir Wm. T. Gairdner, K.C.B., LL.D., M.D.
Jonathan Hutchinson, LL.D., F.R.S.

J. Hughlings Jackson, LL.D., F.R.S.
J. Fletcher Little, M.B., M.R.C.P.
Col. Kenneth McLeod, LL.D., M.D.
Sir John Watt Reid, K.C.B., LL.D., M.D.
Sir John Burdon Sanderson, Bart., LL.D., F.R.S.
Sir John Batty Tuke, M.P., M.D.
Sir Samuel Wilks, Bart., LL.D., F.R.S.

Treasurer: Chas. Theodore Williams, M.D., F.R.C.P.
Dean: Guthrie Rankin, M.D., M.R.C.P.

Council:

Chairman: Jonathan Hutchinson, LL.D., F.R.S.
Vice-Chairman: Malcolm A. Morris, F.R.C.S.

James Berry, B.S., F.R.C.S.
Robt. Bowles, M.D., F.R.C.P.
James Cantlie, B.S., F.R.C.S.
Prof. Crookshank, M.B.
Alderman Crosby, M.D., F.R.C.S.
Alfred L. Galabin, M.D., F.R.C.P.
James F. Goodhart, M.D., F.R.C.P.

Alfred P. Hillier, M.D.
Constantine Holman, M.D.
Boyd Joll, M.B.
Sir William Kynsey, F.R.C.P.
Stephen Mackenzie, M.D., F.R.C.P.
Patrick Manson, F.R.S., LL.D., M.D.

George Oliver, M.D., F.R.C.P.
W. Miller Ord, M.D., F.R.C.P.
Solomon Smith, M.D., M.R.C.P.
James Taylor, M.D., F.R.C.P.
Seymour Taylor, M.D., F.R.C.P.
StClair Thomson, M.D., F.R.C.S.

Medical Superintendent:

A. E. Hayward Pinch, F.R.C.S.

The Electrical Standardizing, Testing and Training Institution.

Principal:

HUGH ERAT HARRISON, B.Sc., M.I.E.E.

Gentlemen's Sons Prepared for the ELECTRICAL ENGINEERING PROFESSION.

The training is thoroughly theoretical and practical, the Institution being associated with most of the leading Electrical Firms and Central Electric Lighting Stations, for the express purpose of affording its Students a proper practical insight into their future profession. Prospectus on application to the Secretary.

INSPECTING AND TESTING DEPARTMENT.

The Institution undertakes the inspection and test of electrical plant, and certifies the same either on behalf of Manufacturers or Buyers. Private testing rooms, supplied with current and apparatus, are let to Experimenters. Terms on application to the Secretary.

**FARADAY HOUSE,
CHARING CROSS ROAD, LONDON, W.C.**

Telegraphic Address:—"STANDARDIZING, LONDON."

APPLICATION FOR MEMBERSHIP.

Date

To THE DEAN OF THE

MEDICAL GRADUATES' COLLEGE AND "Polyclinic,"
20, CHENIES STREET, W.C.

Dear Sir,

I desire to join the "Polyclinic" as a Member. When I
Subscriber. hear from you that my application has been approved by the Council,
I shall send you a cheque for my first year's Subscription.

This application is supported by the following Members of the College:

Name.....
Qualification.....
Address.....

Subscription to Journal Order Form.

To THE PUBLISHERS OF THE "Polyclinic,"

MESSRS. JOHN BALE, SONS AND DANIELSSON, LTD.,
83-89, GT. TITCHFIELD STREET,
LONDON, W.

Please forward to me to the undermentioned address.....
Copies of the "Polyclinic" for the coming year (1900). I enclose
Postal Order for Twelve Shillings and Sixpence.

Name.....
Address.....

J. H. MONTAGUE,

SURGICAL INSTRUMENT MAKER AND CUTLER.

By Appointment to—
The Honourable Council of
India,
St. George's Hospital,
Westminster Hospital, &c.

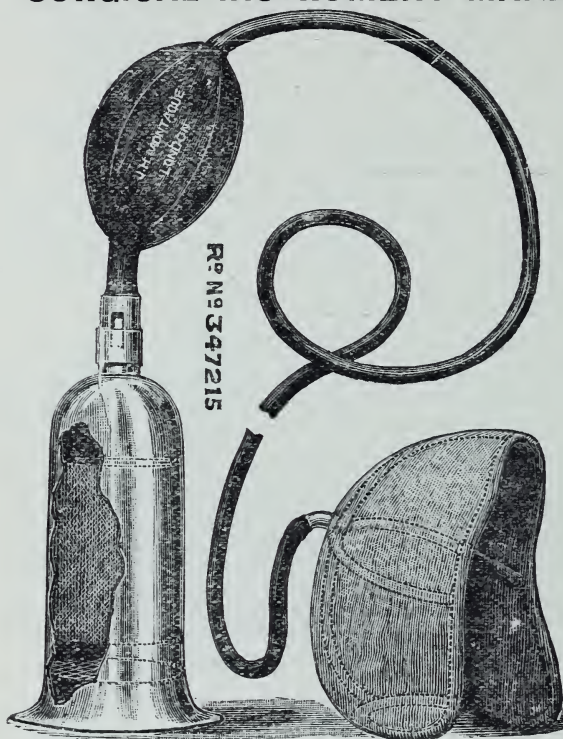
TELEGRAPHIC ADDRESS—
"MASTOID, LONDON."

FLUX'S CHLOROFORM INHALER.

**For the safe
administration
of Chloroform.**

Vide the Lancet, Feb. 3rd, 1900.

Price, complete in Case,
£1 15 0

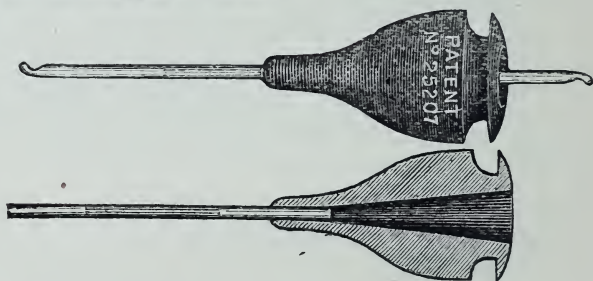


PATENT VACCINE EXPELLER.

Price 1/6 each,
or, 16/- per doz.

To meet the requirements
of the
Local Government Board.

Can be thoroughly
Sterilised.



PATENT ATMO-THERME STERILISER,

Made in Tin, 14 by 8 Price, £2 10 0

„ Copper, N.P., 14 by 8 „ £5 5 0

Any size made to order

CARTER BRAINE'S IMPROVED ORMSBY'S INHALER,

With Attachment for the Administration of A. C. E. Mixture and Chloroform.

Price Complete, Nickel Plated £3 3 0

COMPLETE OUTFITS for the PRODUCTION of RONTGEN'S "X" RAYS.

Skiagraphs Taken at any Time, or by Appointment.

101, NEW BOND STREET, LONDON, W.

COLLEGE LECTURES AND CLASSES

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

MICHAELMAS TERM, 1900.

PRACTICAL CLASSES.

| | | |
|--|---|----------------------------------|
| Applied Anatomy (Medical and Surgical), Physical Diagnosis | { | Seymour Taylor, M.D., F.R.C.P. |
| | | J. Edward Squire, M.D., M.R.C.P. |
| | | James Cantlie, M.B., F.R.C.S. |
| | | Albert Carless, M.S., F.R.C.S. |
| Clinical Examination of the Nervous System | { | James Taylor, M.D., F.R.C.P. |
| | | Harry Campbell, M.D., F.R.C.P. |
| Practical Ophthalmology: the use of the Ophthalmoscope and Refraction | { | E. Treacher Collins, F.R.C.S. |
| | | W. Holmes Spicer, M.B., F.R.C.S. |
| | | John Griffith, F.R.C.S. |
| Practical Otology | { | J. Dundas Grant, M.D., F.R.C.S. |
| | | Richd. Lake, F.R.C.S. |
| Practical Rhinology and Laryngology | { | StClair Thomson, M.D., F.R.C.S. |
| | | Herbert Tilley, M.D., F.R.C.S. |
| | | W. Jobson Horne, M.B., M.R.C.P. |
| The Application of the Röntgen Rays | | F. Harrison Low, M.B. |
| Clinical Microscopy | | A. E. Hayward Pinch, F.R.C.S. |

COURSES OF LECTURES.

| | |
|--|------------------------------------|
| General Ophthalmology... .. | R. Marcus Gunn, M.B., F.R.C.S. |
| Lectures and Demonstrations on Diseases of the Skin | Phineas S. Abraham, M.D., F.R.C.S. |
| Administration of Anæsthetics | J. F. W. Silk, M.D. |
| Diseases of Children | G. F. Still, M.D., M.R.C.P. |

CLASSES IN ASSOCIATION WITH THE COLLEGE.

| | |
|----------------------------------|-----------------------------------|
| Practical Bacteriology | Professor Crookshank, M.B. |
| Mental Diseases | Maurice Craig, M.D., M.R.C.P. |
| Hygiene and Public Health | A. Wynter Blyth, M.R.C.S., F.C.S. |

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, W.C.

MICHAELMAS TERM, 1900.

Commences Monday, Sept. 17th; ends Friday, Oct. 26th.

CLINICAL LECTURES will be given on alternate Wednesdays at 5 P.M., commencing Wednesday, Sept. 12th.

CLINICAL CONSULTATIONS AT 4 P.M.

Mondays (Skin); Tuesdays (Medical); Wednesdays (Various); Thursdays (Surgical); Fridays (Eye, Ear, Throat, and Nose).

PRACTICAL CLASSES.

- Applied Anatomy (Medical and Surgical), Physical Diagnosis. Tuesdays and Thursdays, at 6 P.M. Commences Tuesday, Sept. 18th. Fee £2 2s. Dr. J. E. Squire and Mr. A. Carless.
- Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M. Commences Friday, Sept. 21st. Fee, £2 2s. Dr. Harry Campbell.
- Practical Application of Röntgen Rays. Thursdays, 3 P.M. Commences Thursday, Sept. 20th. Fee, £2 2s. Dr. Harrison Low.
- Practical Ophthalmology: the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M. Commences Friday, Sept. 21st. Fee, £2 2s. Mr. John Griffith.
- Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commences Wednesday, Sept. 19th. Fee, £2 2s. Dr. W. Jobson Horne.
- Practical Otology. Mondays, 5 to 7 P.M. Commences Monday, Sept. 17th. Fee, £2 2s. Mr. R. Lake.
- Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30 P.M. Commences Monday, Sept. 17th. Fee, £2 2s. Mr. Hayward Pinch.
- Composition fee for any three of above courses, £5 5s.

LECTURES.

(Conditional upon a minimum number of entries being received.)

- Diseases of the Eye. Mr. Marcus Gunn.
 Diseases of the Skin. Dr. Phineas Abraham.
 Administration of Anæsthetics. Dr. Silk.
 Diseases of Children. Dr. G. F. Still.

Fee for any one course of Six Lectures, £1 1s.

LABORATORY AND CLINICAL CLASSES.

- Practical Bacteriology. Daily, 10 A.M. to 1 P.M., and 2 to 5 P.M. Fee, £5 5s. Professor Crookshank.
- Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee, £2 2s. Professor Crookshank.
- Hygiene and Public Health. Fee, £2 2s. Mr. Wynter Blyth.
- Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.
- Morbid Conditions of the Urine and their Clinical Significance. Fee, £2 2s.

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

Extra classes may be formed to suit the convenience of practitioners unable to attend those already provided.

PLASMON

NATURE'S NUTRIENT.

Soluble, Digestible, Natural Albumen.

Pure. Tasteless. Odourless. Nutritious. Cheap.

PLASMON is an absolutely pure, soluble milk albumen, free from all chemicals, but contains 90 per cent. nitrogen and the natural salts of fresh milk, and being tasteless and odourless, is capable of being used in any and every form of food.

PLASMON replaces all other nitrogenous substances in the dietary of the healthy and of the weak, and of the aged and the young.

PLASMON is used in many of the principal Hospitals, and is prescribed by many medical men throughout the country.

Dr. C. VIRCHOW, of Berlin, in his official report on Plasmon states:

"From my experience I can recommend the administration of PLASMON. PLASMON is an albumen preparation containing a very high proportion of nitrogen, and extremely digestible. As practical trials have demonstrated, it can replace all other animal albumen foods, and is superior even to meat in nutrient value."

Dr. PRAUSNITZ, Professor and Principal of the German State Department of Hygiene, in his official report, states:—

"There is no food preparation known to us equal to PLASMON, either as regards constancy of composition, as guaranteed by its source, or in respect to the proportion, solubility, and digestibility of the nutritive constituents."

Dr. HOFMANN, Privy Medical Councillor, State Professor of Hygiene, reporting to the Lepsic University, says:—

"The PLASMON taken fully replaced the albumen of ordinary meat diet."

"PLASMON is an albumen preserve which contains in a minimum space the maximum quantity of indispensable food."

Dr. I. B. RAVENS, Principal Medical Officer of the State Kropp Asylums for Imbecile Children and Foundlings, says:—

"Whoever sees the children and patients fed on PLASMON at once recognises from their appearance the wonderful success of its administration."

In the Report of a case of Enteric Fever of three months' duration, which appeared in the **BRITISH MEDICAL JOURNAL** of June 2nd, 1900, page 1389, the writer points out that—

"The patient was ordered, in addition to his milk, a teaspoonful of PLASMON every alternate hour. This was taken without difficulty; there was no rise in temperature, and the bowels were moved only once in the 24 hours. This was practically the turning-point in the patient's illness. The PLASMON diet was continued. He was allowed up on the one-hundredth day of his illness."

The writer adds:—

"The question of feeding typhoid patients has of late attracted considerable attention, and the commonly accepted rule that no solid food should be given until the temperature has been normal for ten days may sometimes be departed from with advantage. In this particular case a high temperature was persistently maintained until some addition was made to the orthodox 3 pints of milk in the 24 hours. The selection of an appropriate food with which to commence is one which requires much consideration. White of egg is undoubtedly very useful, but for this purpose I think very highly of PLASMON, an albumen preparation made from milk, from which the fat has been removed. It is a colourless dry powder, free from odour and taste, and is undoubtedly a valuable nutritive agent. I usually give it in teaspoonful doses in five ounces of water every alternate hour. It is assimilated without difficulty, and produces no rise in temperature even in the early stages of typhoid. It forms a useful addition to beef-tea, soups and other articles of dietary."

For Particulars and Free Samples apply to—

The PLASMON SYNDICATE, Ltd.,

**56, Duke St., Grosvenor Square,
London.**

PRICE:

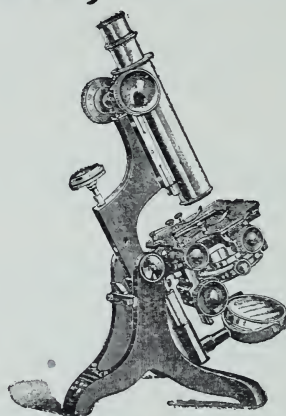
| | | |
|-------------------|-------------------------|-----|
| PLASMON POWDER | Packets about 1 lb. . . | 2/6 |
| | " " ½ lb. . . | 1/4 |
| | " " ¼ lb. . . | -/9 |

BACTERIOLOGY.

C. BAKER, Manufacturers & Agents.

All Apparatus
necessary for
research
Microscopes
(English and
Continental).

Catalogues Post Free
to readers of this
Journal, apply—



Microtomes.
Stains.
(Grubler's)
Hæmometers.
Polarimeters.
Centrifuges.
Incubators.
Sterilisers.

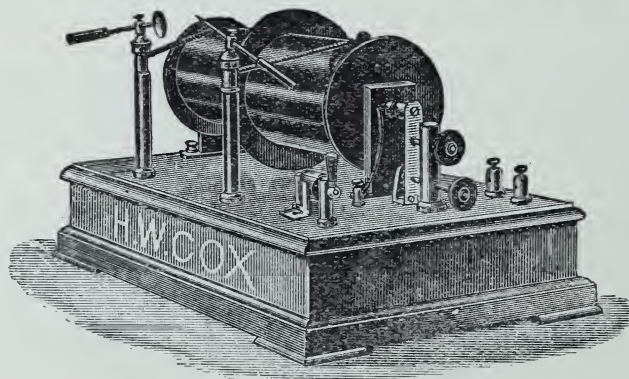
244, HIGH HOLBORN, W.C.

BLOOD EXAMINATION.

X - RAYS APPARATUS

Of the Highest Quality and Finish only.

BUY DIRECT FROM THE MAKERS.



As supplied by us to
H.M. Government for use
in South Africa, The "Prin-
cess of Wales" Hospital
Ship, Scottish National Red
Cross Hospital, The Welsh
Hospital, The Yeomanry
Hospital, Medical Men,
Hospitals, Chemists, and
X-Ray Workers in all parts
of the World. Our Appa-
ratus gives the very best
results, and we guarantee
all our coils against break-
ing down.

Our price list, with
simple instructions how to
set about work, will be sent
post free to readers of the
"Polyclinic."

HARRY W. COX, Ltd.,

Manufacturing Electricians,

10, 11, and 28, CURSITOR STREET, CHANCERY LANE, W.C.

SPECIAL DARK ROOM FOR DEMONSTRATIONS.

Concise yet comprehensive summaries of all in periodical literature important to the practitioner. Facts, not mere opinions, characterise the "Review," instead of the commonplace remarks and indiscriminate and useless notices of crude and unproved views which constitute many so called "Epitomes."

The Medical Review

(MEDICAL AND SURGICAL REVIEW OF REVIEWS.)

AN INDEXED AND ILLUSTRATED
MONTHLY RECORD OF ALL THAT IS IMPORTANT TO THE PRACTITIONER IN THE
MEDICAL PERIODICALS IN THE WORLD.

PRINTED IN LARGE CLEAR TYPE, ON SUPERFINE PAPER.

Subscription £1 per annum, post free to any part of the world.

By the suppression of all unessential matter, a paper written with any definite object—and such alone is valuable—can generally be compressed into a comparatively brief report, and yet remain a clear and readable account of the subject, so that nothing of importance is lost, and often, in lucidity, much is gained. Merely to mention a few of the leading features of an article serves no useful purpose.

" . . . A great boon to the profession all over the world. . . . I applaud not only your scheme, but the manner of its execution. . . ."—JONATHAN HUTCHINSON, LL.D., F.R.S., Ex-President of the Royal College of Surgeons, England.

"Extremely useful to the busy practitioner."—*Lancet*.

" . . . I think you are about to fill a very great want. . . ."—T. CLIFFORD ALLBUTT, M.A., M.D., F.R.C.P., F.R.S., Regius Prof. of Physic, Cambridge University.

" . . . It would be impossible for such a journal not to take at once a first place. . . ."—*Birmingham Medical Review*.

" . . . Of great value to the general practitioner, and to teachers and authors. . . ."—BYROM BRAMWELL, M.D., F.R.C.P., Edin.

"Destined to the greatest and legitimate success. . . . Well edited. Giving an exact account of all of importance in science and medical practice."—*Journal des Practiciens*.

" . . . The 'Review' brings me into touch with methods and ideas which I could not possibly have otherwise obtained. . . . No surgeon can afford to do without such an excellent index to scientific progress."—J. O'CONOR, M.A., M.D., Senior Medical Officer, British Hospital, Buenos Ayres.

IMPORTANT TO NEW SUBSCRIBERS.

BACK NUMBERS.

The attention of New Subscribers is called to the desirability of applying for Vols. I. and II. of the "REVIEW" before they are out of print.

As the important facts recorded in the "REVIEW" are not presented as isolated contributions only, but as collated records, the bound volumes present, in a unique manner, the definite progress of medical science, and render all that is important to the practitioner in the current medical periodicals readily accessible.

Already one of the parts has had to be reprinted, and now only a limited number of Vol. II. is available for new subscribers. The first 500 new subscribers to the "REVIEW" for this current year, who purchase Vol. II. will each be entitled to a bound copy of Vol. I. (Nos. 1, 2, and 3) *free of charge*.

The price for Vol. II., crown 4to, cloth, is 21/- net.

All communications to be addressed to the SECRETARY, Cheques and Postal Orders should be made payable to THE MEDICAL AND SURGICAL "REVIEW OF REVIEWS," LIMITED, 12, Norfolk Street, Strand, London, W.C., and crossed "BROWN, JANSON & Co."

NEW SYDENHAM SOCIETY.

SALE OF SURPLUS VOLUMES.

IN order to reduce its Stock-in-hand, the Society is now offering many of the past Volumes at almost nominal cost. Among them are those of Graves, Niemeyer, Stokes, Trousseau (Vols. i., iv., v.), Charcot, Marie, Spiegelberg, Pozzi, and many others. The Volumes have been re-arranged in Guinea Sets. In some instances as many as Eight Volumes may be obtained for One Guinea. Full Catalogues may be obtained from

Mr. H. K. LEWIS, 136, Gower Street, W.C.

The following are the Contents of some of the Sets :—

- SET I.—*Three Vols.*
Two Monographs on Malaria and the Parasites of Malarial Fevers.
Laveran on Paludism.
Selected Monographs, Vol. 121, on Malaria, &c.
- SET III.—*Five Vols.*
Binz's Lectures on Pharmacology, 2 Vols.
Naunyn on Cholelithiasis.
Ewald's Disorders of Digestive Organs, 2 Vols.
- SET V.—*Eight Vols.*
The Works of Sir William Gull, 2 Vols.
The Collected Works of Dr. Addison.
Latham's Works, 2 Vols.
Selections from the Works of Colles.
Warburton Begbie's Works.
Graves's Clinical Medicine, 2 Vols.
- SET VII.—*Six Vols.*
Selected Monographs on Dermatology (Unna, Nielsen, Duhring, Bronson, Blanc, Berger, Prince-Morrow).
Essays on Acromegaly (Pierre Marie and Souza Leite).
The Works of Sir William Gull, 2 Vols.
Monographs and Lectures from German Sources, Series iii.
Selected Monographs, Vol. 110.
- SET VIII.—*Seven Vols.*
Billroth's Clinical Surgery (Illustrated).
Essays on Micro-Parasites in Disease. Selected by Watson Cheyne (Illustrated).
Monographs and Lectures from German Sources, Series iii., Vol. 148.
Essays on Acromegaly (Pierre Marie and Souza Leite).
Memoirs on Diphtheria.
Lancereaux's Syphilis, 2 Vols.
- SET X.—*Eight Vols.*
Selected Lectures and Papers from Foreign Sources, Vol. 161.
Naunyn on Cholelithiasis.
Hebra's Diseases of the Skin, Vols. ii., iii., iv. and v.
Griesinger on Mental Pathology.
Niemeyer's Lectures on Pulmonary Consumption.
- SET XI.—*Seven Vols.*
Naunyn on Cholelithiasis.
Stricker's Histology, Human and Comparative, 3 Vols. (Illustrated).
Selections from the Works of Dr. Duchenne.
Koch's Researches on Wound Infection.
Stokes on Diseases of the Chest.

THERE ARE XXIV. SUCH SETS.

Jas. Swift & Son,

MANUFACTURING OPTICIANS,

Solely appointed to the Army Medical Department, War Office, for the supply of Microscopes.

Patent 4-legged Microscope, with Coarse and Fine Adjustment, Large Stage suitable for Bacteriological work, Flat and Concave Mirrors, $\frac{3}{4}$ " & $\frac{1}{2}$ " Objectives (first quality), one Ocular and Iris Diaphragm. The whole packed in Mahogany Cabinet,

£7 0 0

SPECIAL MICROSCOPES FOR BACTERIOLOGISTS.

Prospectus Free on Application.

81, TOTTENHAM COURT ROAD, W.



Demy 8vo. Fully Illustrated. Price 1s. 6d. net; Post Free 1s. 8d

BRITISH SANATORIA

FOR THE

OPEN-AIR TREATMENT OF TUBERCULOSIS.

[Reprinted with additions and alterations from the "West London Medical Journal."]

N.B.—This book will be found invaluable to Medical Men as well as the general public seeking information on the above subject.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Great Titchfield Street, London, W.

PERSONS desiring to communicate with THE LONDON SCHOOL OF TROPICAL MEDICINE should address The Medical Tutor, London School of Tropical Medicine, Seamen's Hospital, Royal Albert Dock, E., or The Secretary, P. Michelli, Esq., Seamen's Hospital, Greenwich, S.E.

THE JOURNAL OF TROPICAL MEDICINE.

A MONTHLY JOURNAL DEVOTED TO MEDICAL, SURGICAL AND GYNÆCOLOGICAL WORK IN THE TROPICS.

Edited by James Cantlie, M.B., F.R.C.S., and W. J. Simpson, M.D., F.R.C.P.

Published by JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Great Titchfield St., London, W.

Subscription, 17/- per annum, payable in advance.

With Illustrations, 808 pages, crown 8vo, 12s. 6d.

AN INDEX OF MEDICINE:

A Manual for the Use of Senior Students and Others,

BY

SEYMOUR TAYLOR, M.D., F.R.C.P.,

Physician to the West London Hospital.

PRESS OPINIONS.

The Lancet.—"Dr. Seymour Taylor may certainly be congratulated on the success of his labours. He has produced exactly what he desired, and the book may confidently be recommended to those for whom it is intended."

The British Medical Journal.—"As a supplement to the larger standard treatises, and so as a means of codifying the knowledge of the more advanced, it will prove invaluable."

London: SMITH, ELDER & CO.

THE STUDENT'S Laryngology Set of Instruments.

Specially designed to meet the requirements of the Classes held
at the Polyclinic and Medical Graduates' College, London.

THIS Set consists of the following Instruments of best quality, and is supplied either in plain cardboard box or in leather-covered cases as under :—

- Head Mirror, with either band or spectacle frames.
- 3 Laryngeal Mirrors of different sizes, fitting into one metal handle.
- 1 Post Nasal Mirror, in metal handle.
- 2 Laryngeal Mirrors, marked "L," in ivory handle. } For Syphilitic Cases
- 1 Tongue Depressor, marked "L." } (Lues).
- 1 do. do.
- 1 Nasal Speculum.
- 1 Set of 3 Aural Specula.
- 1 Flexible Probe.
- 1 Pair of Dressing Forceps.

Price, Complete in Cardboard Box, £2 10s. net, or in leather-covered Case
with Catch, 9s. extra.

Forceps for Peritonsillar Abscess

(Suggested by Dr. StClair Thomson).



THESE Forceps are a slight modification of Lord Lister's Sinus Forceps. Being intended chiefly for use in the Throat and Nose, they have been made with a crank handle, so that the field of operation is not concealed by the surgeon's hand. They will be found particularly useful for opening peritonsillar abscesses. When the abscess is pointing, generally at the upper end of the tonsil, firm pressure with the extremity of the Forceps will readily detect the site of suppuration and with slight increase in force the point can be made to penetrate the abscess easily. In withdrawing them the two blades should be separated as in Hilton's method.

The Forceps are also very useful in removing foreign bodies from the nose.

Price, Nickel-plated, 5s. 6d. each, or with Aseptic Joint, 6s. 6d.

ALLEN & HANBURY, Ltd.,

Surgical Instrument Manufacturers,

Surgical Instrument Department : 48, WIGMORE STREET, W.

CITY HOUSE :

INSTRUMENT FACTORY :

PLOUGH COURT, LOMBARD STREET, E.C. 59, WEYMOUTH STREET, W.

LONDON.

The Polyclinic

BEING THE JOURNAL OF THE

Medical Graduates' College London.

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION
OF THE MUSEUM AND LIBRARY COMMITTEE, BY

JONATHAN HUTCHINSON.

COMMITTEE OF CO-OPERATION.

T. CLIFFORD ALLBUTT.
ALFRED GALABIN.
STEPHEN MACKENZIE.
WM. MILLER ORD.

SIR WM. BROADBENT.
J. HUGHLINGS JACKSON.
MALCOLM MORRIS.
C. THEODORE WILLIAMS.

CONTENTS.

| | PAGE |
|---|------|
| THE ADVANTAGES OF CIRCUMCISION | 129 |
| SOME FALLACIES AS TO SYPHILIS | 132 |
| THE FAROE ISLANDS | 135 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| PANCREATITIS, WITH ESPECIAL REFERENCE TO CHRONIC PANCREATITIS: | |
| A. W. MAYO ROBSON, F.R.C.S.Eng. | 140 |
| THE TREATMENT OF LUPUS VULGARIS, MORE ESPECIALLY BY THYROID FEEDING: | |
| DR. J. J. PRINGLE | 150 |
| THE "CACODYLIC MEDICATION": | |
| WM. EWART, M.D.CANTAB., F.R.C.P. | 157 |
| NOTES OF CASES DEMONSTRATED IN CONSULTATIONS: | |
| MEDICAL CASES: DR. GUTHRIE RANKIN... .. | 161 |
| CASES WITH COMMENTS FROM THE SURGICAL CLINIC: MR. HUTCHINSON | 167 |
| REVIEWS AND NOTICES OF BOOKS... .. | 170 |
| NOTES FROM THE CONGRESSES | 172 |
| MUSEUM NOTES | 177 |
| CORRESPONDENCE AND ANSWERS | 191 |

Published by

JOHN BALE, SONS & DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, LONDON, W.

Price: One Shilling.

'Kepler'

.. Solution



WITHOUT offending the palate or disturbing the digestion, 'Kepler' Solution ensures the absorption of cod liver oil to an extent hitherto impossible. No plain or prepared oil is so acceptable to fastidious invalids and young children or so easily assimilated as this intimate incorporation of the finest Norwegian Cod Liver Oil in 'Kepler' Malt Extract. It is the best preparation of malt and oil which can be produced from the finest materials by the latest and most original methods under the control of experts who have devoted many years to studying the subject. 'Kepler' Solution is supplied in small and large bottles.



Burroughs Wellcome & Co.,

LONDON and SYDNEY.

[COPYRIGHT]

F 9 C

THE PRACTITIONER.

A JOURNAL OF PRACTICAL MEDICINE.

EDITED BY

MALCOLM MORRIS.

The SEPTEMBER PART, Price 2/-, contains:—

THE MONTH:—

The B.M.A. at Ipswich.
Editor-baiting as a new Form of Sport.
A Cowardly Council.
An Unfounded Charge.
The Reconstruction of the Association.
The Real Obstacle to Reform.
The National Hospital for the Paralysed and Epileptic.
The Complaints of the Medical Staff.

Lay Control in Hospital Management.
The Need of a Medical Element in Hospital Boards.
The Board and the Brewery.
Hospital Managers and "Swelled Head."
Discreditable Methods of Controversy.
The Question for the Governors.
Sir William Stokes.
The "Indian Medical Gazette."
Some Humours of Bacteriology.

ORIGINAL COMMUNICATIONS:—

An Address on the Surgical Treatment of Trigeminal Neuralgia. By Victor Horsley, F.R.S., F.R.C.S.
A Clinical Lecture on Pelvic Pain. By G. Drummond Robinson, M.D., B.S.Lond., M.R.C.S.
Some Disorders of Memory associated with Epilepsy with Special Reference to "Reminiscences." By H. Campbell Thomson, M.D.Lond., M.R.C.P.
Notes on a Case of Gastric Tetany. By J. Christian Simpson, M.D.

MEDICAL MEN OF LETTERS:—

François Rabelais. (*With Portrait.*)

A MEDICO-LITERARY CAUSERIE:—

Poisons and Poisoners: Old and New. II.

PUBLIC HEALTH:—

Hospital Administration in relation to the Aerial Convection of Small-pox. (*Continued.*)

A REVIEW OF THE MEDICAL SCIENCES:—

Diseases of the Blood and Ductless Glands. By T. N. Kelynack, M.D., M.R.C.P. (*Illustrated.*)
Orthopædic Surgery. By J. Jackson Clarke, M.B.Lond., F.R.C.S. (*Illustrated.*)
Venereal Diseases. By J. Ernest Lane, F.R.C.S.

REVIEWS OF BOOKS. (*Illustrated.*) LITERARY GOSSIP.

PRACTICAL NOTES. A MEDICAL CALENDAR.

Annual Subscription, 21s., post free.

CASSELL & Co., Ltd., London, Paris, New York & Melbourne.

THE MEDICAL GRADUATES' COLLEGE & POLYCLINIC

22, CHENIES STREET, LONDON, W.C.



Vice-Patrons:

THE LORD IVEAGH, K.P., LL.D.
THE RIGHT HON. LORD STRATHCONA AND MOUNT ROYAL, G.C.M.G.
THE RIGHT HON. A. J. BALFOUR, M.P., LL.D.
THE RIGHT HON. LORD AVEBURY, F.R.S.

President:

Sir Wm H. Broadbent, Bart., LL.D., F.R.S.

Vice-Presidents:

Prof. Clifford Allbutt, LL.D., F.R.S.
Sir John Banks, K.C.B., M.D.
Sir James Crichton Browne, LL.D., F.R.S., M.D.
Thomas Bryant, F.R.C.S.
Sir Joseph Fayrer, K.C.S.I., F.R.S., M.D.
Sir Wm. T. Gairdner, K.C.B., LL.D., M.D.
Jonathan Hutchinson, LL.D., F.R.S.
J. Hughlings Jackson, LL.D., F.R.S.

J. Fletcher Little, M.B., M.R.C.P.
Col. Kenneth McLeod, LL.D., M.D.
Prof. William Osler, LL.D., M.D.
Sir John Watt Reid, K.C.B., LL.D., M.D.
Sir John Burdon Sanderson, Bart., LL.D., F.R.S.
Sir John Batty Tuke, M.P., M.D.
Sir Samuel Wilks, Bart., LL.D., F.R.S.

Treasurer: Chas. Theodore Williams, M.D., F.R.C.P.
Dean: Guthrie Rankin, M.D., M.R.C.P.

Council:

Chairman: Jonathan Hutchinson, LL.D., F.R.S.
Vice-Chairman: Malcolm A. Morris, F.R.C.S.

James Berry, B.S., F.R.C.S.
Robt. Bowles, M.D., F.R.C.P.
James Cantlie, B.S., F.R.C.S.
Prof. Crookshank, M.B.
Alderman Crosby, M.D., F.R.C.S.
Alfred L. Galabin, M.D., F.R.C.P.
James F. Goodhart, M.D., F.R.C.P.

Alfred P. Hillier, M.D.
Constantine Holman, M.D.
Boyd Joll, M.B.
Sir William Kynsey, F.R.C.P.
Stephen Mackenzie, M.D., F.R.C.P.
Patrick Manson, F.R.S., LL.D., M.D.

George Oliver, M.D., F.R.C.P.
W. Miller Ord, M.D., F.R.C.P.
Solomon Smith, M.D., M.R.C.P.
James Taylor, M.D., F.R.C.P.
Seymour Taylor, M.D., F.R.C.P.
StClair Thomson, M.D., F.R.C.S.

Medical Superintendent:

A. E. Hayward Pinch, F.R.C.S.

The Electrical Standardizing, Testing and Training Institution.

Principal:

HUGH ERAT HARRISON, B.Sc., M.I.E.E.

Gentlemen's Sons Prepared for the ELECTRICAL ENGINEERING PROFESSION.

The training is thoroughly theoretical and practical, the Institution being associated with most of the leading Electrical Firms and Central Electric Lighting Stations, for the express purpose of affording its Students a proper practical insight into their future profession. Prospectus on application to the Secretary.

INSPECTING AND TESTING DEPARTMENT.

The Institution undertakes the inspection and test of electrical plant, and certifies the same either on behalf of Manufacturers or Buyers. Private testing rooms, supplied with current and apparatus, are let to Experimenters. Terms on application to the Secretary.

FARADAY HOUSE,
CHARING CROSS ROAD, LONDON, W.C.

Telegraphic Address:—"STANDARDIZING, LONDON."

READY SHORTLY.

OUTLINES FOR DISSECTORS

Issued in Four Parts. Each Part 1/6 net.

| | |
|---------------------------------------|---|
| Part I. Upper Extremities—Right Side. | Part III. Lower Extremities—Right Side. |
| „ II. „ „ —Left Side. | „ IV. „ „ —Left Side. |

BY

F. G. PARSONS, F.R.C.S.,

Lecturer and Senior Demonstrator of Anatomy at St. Thomas's Hospital Medical School; Examiner in Anatomy for the Fellowship of the Royal College of Surgeons of England.

PREFACE.

There is little doubt that drawing is a great aid to observation, and one of the objects at which most teachers of anatomy aim is to train their students' powers of accurate observation. Many people, unfortunately, have no skill in drawing, and to meet this difficulty I have given my own students a series of outlines to fill in. The plan has so far worked well, and I am publishing these diagrams of the upper extremity in the hope that they may be of use to others.

To be of real service they should be filled in from the part itself. First the arteries and veins should be drawn in red and blue chalk, then the nerves in heavy black lines, afterwards the direction and arrangement of the fibres of the muscles should be sketched, and the point of entry of their nerves noticed; the fleshy parts of the muscles may be shaded lightly with red, while the tendinous parts are left white.

If all this is thoroughly done the student will find that he has noticed a great many points which he would otherwise probably have failed to do, and he will have, in addition, a more or less accurate record of the part he dissected.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Gt. Titchfield St., W.

J. H. MONTAGUE,

SURGICAL INSTRUMENT MAKER AND CUTLER.

By Appointment to—
The Honourable Council of
India,
St. George's Hospital,
Westminster Hospital, &c.

TELEGRAPHIC ADDRESS—
"MASTOID, LONDON."

FLUX'S CHLOROFORM INHALER.

**For the safe
administration
of Chloroform.**

Vide the Lancet, Feb. 3rd, 1900.

Price, complete in Case,
£1 15 0



PATENT VACCINE EXPELLER.

Price 1/6 each,
or, 16/- per doz.

To meet the requirements
of the
Local Government Board.

Can be thoroughly
Sterilised.

PATENT ATMO-THERME STERILISER,

Made in Tin, 14 by 8 Price, £2 10 0

" Copper, N.P., 14 by 8 " £5 5 0

Any size made to order

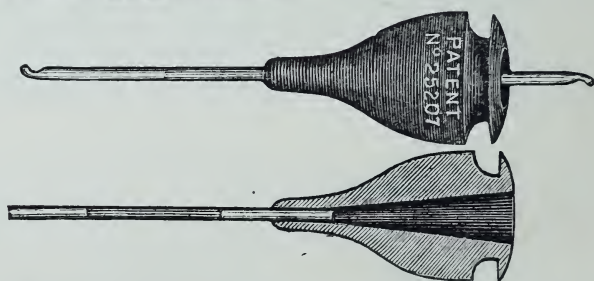
CARTER BRAINE'S IMPROVED ORMSBY'S INHALER,

With Attachment for the Administration of A. C. E. Mixture and Chloroform.

Price Complete, Nickel Plated £3 3 0

COMPLETE OUTFITS for the PRODUCTION of RONTGEN'S "X" RAYS.

Skiagraphs Taken at any Time, or by Appointment.



101, NEW BOND STREET, LONDON, W.

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CONSULTATIONS AND LECTURES

From **SEPTEMBER** to **DECEMBER, 1900.**

Consultations at 4 p.m.

* Clinical Lectures at 5 p.m.

SPECIAL COURSES OF LECTURES AT 5.15 P.M.

| MONDAYS. (<i>Skin</i>) | TUESDAYS. (<i>Medical</i>) | WEDNESDAYS. (<i>Various</i>) | THURSDAYS. (<i>Surgical</i>) | FRIDAYS. (<i>Eye, Ear, Nose, and Throat.</i>) |
|--------------------------------------|---------------------------------------|--|-----------------------------------|--|
| September 3 College opens | September 4 Dr. W. Ewart | September 5 <i>Surgical Cons.</i> Mr. James Berry | September 6 Mr. Hutchinson | September 7 Mr. J. Griffith |
| September 10 Mr. Hutchinson | September 11 Dr. Seymour Taylor | *September 12 <i>Clinical Lecture.</i> Dr. Byrom Bramwell | September 13 Mr. Hutchinson | September 14 Dr. Dundas Grant |
| September 17 Dr. A. Whitfield | September 18 Dr. James Taylor | September 19 <i>Cons. Pediatrics.</i> Dr. G. F. Still | September 20 Mr. Hutchinson | September 21 Mr. N. Maclellan |
| September 24 Mr. W. Anderson | September 25 Dr. C. Theo. Williams | *September 26 <i>Clinical Lecture.</i> Dr. A. E. Sansom | September 27 Mr. Hutchinson | September 28 Dr. St. Clair Thomson |
| October 1 Dr. T. Colcott Fox | October 2 Dr. J. E. Squire | October 3 <i>Medical Cons.</i> Dr. Alfred Hillier | October 4 Mr. Hutchinson | October 5 Mr. R. Lake |
| October 8 Dr. Jas. Galloway | October 9 Dr. James Taylor | *October 10 <i>Clinical Lecture.</i> Sir Wm. Gowers | October 11 Mr. Hutchinson | October 12 Mr. Treacher Collins |
| October 15 Mr. Malcolm Morris | October 16 Sir Wm. Broadbent | October 17 <i>Surgical Cons.</i> Mr. J. Cantlie | October 18 Mr. Hutchinson | October 19 Dr. St. Clair Thomson |
| October 22 Dr. T. Colcott Fox | October 23 Dr. Harry Campbell | *October 24th <i>Clinical Lecture.</i> Mr. W. H. A. Jacobson | October 25 Mr. Hutchinson | October 26 Dr. Dundas Grant |
| October 29 Dr. J. F. Payne | October 30 Sir Wm. Broadbent | October 31 <i>Surgical Cons.</i> Mr. Reg'd. Harrison | November 1 Mr. Hutchinson | November 2 Mr. Holmes Spicer |
| November 5 Dr. J. J. Pringle | November 6 Dr. R. L. Bowles | *November 7 <i>Clinical Lecture.</i> Dr. Chris. Childs | November 8 Mr. Hutchinson | November 9 Dr. Herbert Tilley |
| November 12 Mr. Malcolm Morris | November 13 Dr. W. Ewart | November 14 <i>Surgical Cons.</i> Mr. Johnson Smith | November 15 Mr. Hutchinson | November 16 Dr. Dundas Grant |
| November 19 Dr. J. F. Payne | November 20 Dr. S. J. Sharkey | *November 21 <i>Clinical Lecture.</i> Prof. Alfred Carter | November 22 Mr. Hutchinson | November 23 Mr. Holmes Spicer |
| November 26 Dr. Radcliffe Crocker | November 27 Dr. Seymour Taylor | November 28 <i>Cons. Pediatrics.</i> Dr. W. B. Cheville | November 29 Mr. Hutchinson | November 30 Dr. St. Clair Thomson |
| December 3 Mr. W. Anderson | December 4 Dr. Guthrie Rankin | *December 5 <i>Clinical Lecture</i> Sir Hector Cameron | December 6 Mr. Hutchinson | December 7 Mr. R. Lake |
| December 10 Mr. Malcolm Morris | December 11 Dr. Harry Campbell | December 12 <i>Surgical Cons.</i> Mr. B. W. Roughton | December 13 Mr. Hutchinson | December 14 Mr. Treacher Collins |
| December 17 Dr. Jas. Galloway | December 18 Dr. C. Theo. Williams | *December 19 <i>Clinical Lecture.</i> Dr. Burney Yeo | December 20 Mr. Hutchinson | December 21 Dr. Herbert Tilley |

October 12th, 19th, and 26th. Mr. HAYWARD PINCH—"The Clinical Examination of the Blood."

November 2nd, 9th, and 16th. Mr. P. J. FREYER—"Some Practical Points in the Surgery of the Urinary Organs."

December 3rd, 10th, and 17th. Dr. STCLAIR THOMSON—"The Surgical Anatomy of the Nose and Accessory Sinuses, including Nasal Suppuration."

GUTHRIE RANKIN, M.D., *Dean.*

A. E. HAYWARD PINCH, F.R.C.S., *Medical Superintendent*

COLLEGE LECTURES AND CLASSES

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

MICHAELMAS TERM, 1900.

PRACTICAL CLASSES.

| | | |
|--|---|---|
| Applied Anatomy (Medical and Surgical), Physical Diagnosis | { | Seymour Taylor, M.D., F.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S. |
| Clinical Examination of the Nervous System | { | James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P. |
| Practical Ophthalmology: the use of the Ophthalmoscope and Refraction | { | E. Treacher Collins, F.R.C.S. W. Holmes Spicer, M.B., F.R.C.S. John Griffith, F.R.C.S. |
| Practical Otology | { | J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S. |
| Practical Rhinology and Laryngology | { | StClair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P. |
| The Application of the Röntgen Rays | | F. Harrison Low, M.B. |
| Clinical Microscopy | | A. E. Hayward Pinch, F.R.C.S. |

COURSES OF LECTURES.

| | | |
|--|-----|------------------------------------|
| General Ophthalmology... .. | ... | R. Marcus Gunn, M.B., F.R.C.S. |
| Lectures and Demonstrations on Diseases of the Skin | ... | Phineas S. Abraham, M.D., F.R.C.S. |
| Administration of Anæsthetics | ... | J. F. W. Silk, M.D. |
| Diseases of Children | ... | G. F. Still, M.D., M.R.C.P. |

CLASSES IN ASSOCIATION WITH THE COLLEGE.

| | | |
|----------------------------------|-----|-----------------------------------|
| Practical Bacteriology | ... | Professor Crookshank, M.B. |
| Mental Diseases | ... | Maurice Craig, M.D., M.R.C.P. |
| Hygiene and Public Health | ... | A. Wynter Blyth, M.R.C.S., F.C.S. |

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, W.C.

COLLEGE LECTURES AND CLASSES

MICHAELMAS TERM, 1900.

Commences Monday, Sept. 17th ; ends Friday, Oct. 26th.

CLINICAL LECTURES will be given on alternate Wednesdays at 5 P.M., commencing Wednesday, Sept. 12th.

CLINICAL CONSULTATIONS AT 4 P.M.

Mondays (Skin) ; Tuesdays (Medical) ; Wednesdays (Various) ; Thursdays (Surgical) ; Fridays (Eye, Ear, Throat, and Nose).

PRACTICAL CLASSES.

- Applied Anatomy (Medical and Surgical), Physical Diagnosis. Tuesdays and Thursdays, at 6 P.M. Commences Tuesday, Sept. 18th. Fee £2 2s. Dr. J. E. Squire and Mr. A. Carless.
- Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M. Commences Friday, Sept. 21st. Fee, £2 2s. Dr. Harry Campbell.
- Practical Application of Röntgen Rays. Thursdays, 3 P.M. Commences Thursday, Sept. 20th. Fee, £2 2s. Dr. Harrison Low.
- Practical Ophthalmology: the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M. Commences Friday, Sept. 21st. Fee, £2 2s. Mr. John Griffith.
- Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commences Wednesday, Sept. 19th. Fee, £2 2s. Dr. W. Jobson Horne.
- Practical Otology. Mondays, 5 to 7 P.M. Commences Monday, Sept. 17th. Fee, £2 2s. Mr. R. Lake.
- Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30 P.M. Commences Monday, Sept. 17th. Fee, £2 2s. Mr. Hayward Pinch.
- Composition fee for any three of above courses, £5 5s.

LECTURES.

(Conditional upon a minimum number of entries being received.)

- Diseases of the Eye. Mr. Marcus Gunn.
Diseases of the Skin. Dr. Phineas Abraham.
Administration of Anæsthetics. Dr. Silk.
Diseases of Children. Dr. G. F. Still.

Fee for any one course of Six Lectures, £1 1s.

LABORATORY AND CLINICAL CLASSES.

- Practical Bacteriology. Daily, 10 A.M. to 1 P.M., and 2 to 5 P.M. Fee, £5 5s. Professor Crookshank.
- Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee, £2 2s. Professor Crookshank.
- Hygiene and Public Health. Fee, £2 2s. Mr. Wynter Blyth.
- Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.
- Morbid Conditions of the Urine and their Clinical Significance. Fee, £2 2s.

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

Extra classes may be formed to suit the convenience of practitioners unable to attend those already provided.

APPLICATION FOR MEMBERSHIP.

Date.....

To THE DEAN OF THE

MEDICAL GRADUATES' COLLEGE AND "Polyclinic,"

20, CHENIES STREET, W.C.

Dear Sir,

I desire to join the "Polyclinic" as a Member.
Subscriber. When I
hear from you that my application has been approved by the Council,
I shall send you a cheque for my first year's Subscription.

Name.....

*This application is
supported by the
following Members
of the College:*

Qualification.....

Address.....

Subscription to Journal Order Form.

To THE PUBLISHERS OF THE "Polyclinic,"

MESSRS. JOHN BALE, SONS AND DANIELSSON, LTD.,

83-89, GT. TITCHFIELD STREET,

LONDON, W.

Please forward to me to the undermentioned address.....

Copies of the "Polyclinic" for the coming year (1900). I enclose
Postal Order for Twelve Shillings and Sixpence.

Name.....

Address.....

PLASMON

NATURE'S NUTRIENT.

Soluble, Digestible, Natural Albumen.

Pure. Tasteless. Odourless. Nutritious. Cheap.

PLASMON is an absolutely pure, soluble milk albumen, free from all chemicals, but contains 90 per cent. nitrogen and the natural salts of fresh milk, and being tasteless and odourless, is capable of being used in any and every form of food.

PLASMON replaces all other nitrogenous substances in the dietary of the healthy and of the weak, and of the aged and the young.

PLASMON is used in many of the principal Hospitals, and is prescribed by many medical men throughout the country.

Dr. C. VIRCHOW, of Berlin, in his official report on Plasmon states:

"From my experience I can recommend the administration of **PLASMON**. **PLASMON** is an albumen preparation containing a very high proportion of nitrogen, and extremely digestible. As practical trials have demonstrated, it can replace all other animal albumen foods, and is superior even to meat in nutrient value."

Dr. PRAUSNITZ, Professor and Principal of the German State Department of Hygiene, in his official report, states:—

"There is no food preparation known to us equal to **PLASMON**, either as regards constancy of composition, as guaranteed by its source, or in respect to the proportion, solubility, and digestibility of the nutritive constituents."

Dr. HOFMANN, Privy Medical Councillor, State Professor of Hygiene, reporting to the Leipzig University, says:—

"The **PLASMON** taken fully replaced the albumen of ordinary meat diet."

"**PLASMON** is an albumen preserve which contains in a minimum space the maximum quantity of indispensable food."

Dr. I. B. RAVENS, Principal Medical Officer of the State Kropp Asylums for Imbecile Children and Foundlings, says:—

"Whoever sees the children and patients fed on **PLASMON** at once recognises from their appearance the wonderful success of its administration."

In the Report of a case of Enteric Fever of three months' duration, which appeared in the **BRITISH MEDICAL JOURNAL** of June 2nd, 1900, page 1389, the writer points out that—

"The patient was ordered, in addition to his milk, a teaspoonful of **PLASMON** every alternate hour. This was taken without difficulty; there was no rise in temperature, and the bowels were moved only once in the 24 hours. This was practically the turning-point in the patient's illness. The **PLASMON** diet was continued. He was allowed up on the one-hundredth day of his illness."

The writer adds:—

"The question of feeding typhoid patients has of late attracted considerable attention, and the commonly accepted rule that no solid food should be given until the temperature has been normal for ten days may sometimes be departed from with advantage. In this particular case a high temperature was persistently maintained until some addition was made to the orthodox 3 pints of milk in the 24 hours. The selection of an appropriate food with which to commence is one which requires much consideration. White of egg is undoubtedly very useful, but for this purpose I think very highly of **PLASMON**, an albumen preparation made from milk, from which the fat has been removed. It is a colourless dry powder, free from odour and taste, and is undoubtedly a valuable nutritive agent. I usually give it in teaspoonful doses in five ounces of water every alternate hour. It is assimilated without difficulty, and produces no rise in temperature even in the early stages of typhoid. It forms a useful addition to beef-tea, soups and other articles of dietary."

For Particulars and Free Samples apply to—

| | | | |
|---------------------------------|---|-------------------------|------------|
| | | PRICE: | |
| PLASMON POWDER | { | Packets about 1 lb. . . | 2/6 |
| | | " " ½ lb. . . | 1/4 |
| | | " " ¼ lb. . . | -/9 |

The PLASMON SYNDICATE, Ltd.,

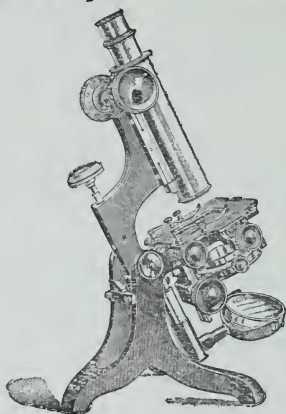
**56, Duke St., Grosvenor Square
London.**

BACTERIOLOGY.

C. BAKER, Manufacturers & Agents.

All Apparatus
necessary for
research
Microscopes
(English and
Continental).

Catalogues Post Free
to readers of this
Journal, apply—



Microtomes.
Stains.
(Grubler's)
Hæmometers.
Polarimeters.
Centrifuges.
Incubators.
Sterilisers.

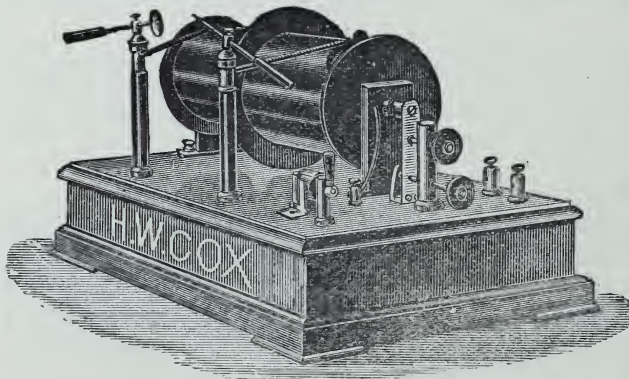
244, HIGH HOLBORN, W.C.

BLOOD EXAMINATION.

X - RAYS APPARATUS

Of the Highest Quality and Finish only.

BUY DIRECT FROM THE MAKERS.



As supplied by us to
H.M. Government for use
in South Africa, The "Prin-
cess of Wales" Hospital
Ship, Scottish National Red
Cross Hospital, The Welsh
Hospital, The Yeomanry
Hospital, Medical Men,
Hospitals, Chemists, and
X-Ray Workers in all parts
of the World. Our Appar-
atus gives the very best
results, and we guarantee
all our coils against break-
ing down.

Our price list, with
simple instructions how to
set about work, will be sent
post free to readers of the
"Polyclinic."

HARRY W. COX, Ltd.,

Manufacturing Electricians,

10, 11, and 28, CURSITOR STREET, CHANCERY LANE, W.C.

SPECIAL DARK ROOM FOR DEMONSTRATIONS.

Concise yet comprehensive summaries of all in periodical literature important to the practitioner. Facts, not mere opinions, characterise the "Review," instead of the commonplace remarks and indiscriminate and useless notices of crude and unproved views which constitute many so called "Epitomes."

The Medical Review

(MEDICAL AND SURGICAL REVIEW OF REVIEWS.)

AN INDEXED AND ILLUSTRATED
MONTHLY RECORD OF ALL THAT IS IMPORTANT TO THE PRACTITIONER IN THE
MEDICAL PERIODICALS IN THE WORLD.

PRINTED IN LARGE CLEAR TYPE, ON SUPERFINE PAPER.

Subscription £1 per annum, post free to any part of the world.

By the suppression of all unessential matter, a paper written with any definite object—and such alone is valuable—can generally be compressed into a comparatively brief report, and yet remain a clear and readable account of the subject, so that nothing of importance is lost, and often, in lucidity, much is gained. Merely to mention a few of the leading features of an article serves no useful purpose.

" . . . A great boon to the profession all over the world. . . . I applaud not only your scheme, but the manner of its execution. . . ."—JONATHAN HUTCHINSON, LL.D., F.R.S., Ex-President of the Royal College of Surgeons, England.

"Extremely useful to the busy practitioner."—*Lancet*.

" . . . I think you are about to fill a very great want. . . ."—T. CLIFFORD ALLBUTT, M.A., M.D., F.R.C.P., F.R.S., Regius Prof. of Physic, Cambridge University.

" . . . It would be impossible for such a journal not to take at once a first place. . . ."—*Birmingham Medical Review*.

" . . . Of great value to the general practitioner, and to teachers and authors. . . ."—BYROM BRAMWELL, M.D., F.R.C.P., Edin.

"Destined to the greatest and legitimate success. . . . Well edited. Giving an exact account of all of importance in science and medical practice."—*Journal des Practiciens*.

" . . . The 'Review' brings me into touch with methods and ideas which I could not possibly have otherwise obtained. . . . No surgeon can afford to do without such an excellent index to scientific progress."—J. O'CONOR, M.A., M.D., Senior Medical Officer, British Hospital, Buenos Ayres.

IMPORTANT TO NEW SUBSCRIBERS.

BACK NUMBERS.

The attention of New Subscribers is called to the desirability of applying for Vols. I. and II. of the "REVIEW" before they are out of print.

As the important facts recorded in the "REVIEW" are not presented as isolated contributions only, but as collated records, the bound volumes present, in a unique manner, the definite progress of medical science, and render all that is important to the practitioner in the current medical periodicals readily accessible.

Already one of the parts has had to be reprinted, and now only a limited number of Vol. II. is available for new subscribers. The first 500 new subscribers to the "REVIEW" for this current year, who purchase Vol. II. will each be entitled to a bound copy of Vol. I. (Nos. 1, 2, and 3) free of charge.

The price for Vol. II., crown 4to, cloth, is 21/- net.

All communications to be addressed to the SECRETARY, Cheques and Postal Orders should be made payable to THE MEDICAL AND SURGICAL "REVIEW OF REVIEWS," LIMITED, 12, Norfolk Street, Strand, London, W.C., and crossed "BROWN, JANSON & Co."

NEW SYDENHAM SOCIETY.

SALE OF SURPLUS VOLUMES.

IN order to reduce its Stock-in-hand, the Society is now offering many of the past Volumes at almost nominal cost. Among them are those of Graves, Niemeyer, Stokes, Trousseau (Vols. i., iv., v.), Charcot, Marie, Spiegelberg, Pozzi, and many others. The Volumes have been re-arranged in Guinea Sets. In some instances as many as Eight Volumes may be obtained for One Guinea. Full Catalogues may be obtained from

Mr. H. K. LEWIS, 136, Gower Street, W.C.

The following are the Contents of some of the Sets:—

- SET I.—*Three Vols.*
Two Monographs on Malaria and the Parasites of Malarial Fevers.
Laveran on Paludism.
Selected Monographs, Vol. 121, on Malaria, &c.
- SET III.—*Five Vols.*
Binz's Lectures on Pharmacology, 2 Vols.
Naunyn on Cholelithiasis.
Ewald's Disorders of Digestive Organs, 2 Vols.
- SET V.—*Eight Vols.*
The Works of Sir William Gull, 2 Vols.
The Collected Works of Dr. Addison.
Latham's Works, 2 Vols.
Selections from the Works of Colles.
Warburton Begbie's Works.
Graves's Clinical Medicine, 2 Vols.
- SET VII.—*Six Vols.*
Selected Monographs on Dermatology (Unna, Nielsen, Duhring, Bronson, Blanc, Berger, Prince-Morrow).
Essays on Acromegaly (Pierre Marie and Souza Leite).
The Works of Sir William Gull, 2 Vols.
Monographs and Lectures from German Sources, Series iii.
Selected Monographs, Vol. 110.
- SET VIII.—*Seven Vols.*
Billroth's Clinical Surgery (Illustrated).
Essays on Micro-Parasites in Disease. Selected by Watson Cheyne (Illustrated).
Monographs and Lectures from German Sources, Series iii., Vol. 148.
Essays on Acromegaly (Pierre Marie and Souza Leite).
Memoirs on Diphtheria.
Lancereaux's Syphilis, 2 Vols.
- SET X.—*Eight Vols.*
Selected Lectures and Papers from Foreign Sources, Vol. 161.
Naunyn on Cholelithiasis.
Hebra's Diseases of the Skin, Vols. ii., iii., iv. and v.
Griesinger on Mental Pathology.
Niemeyer's Lectures on Pulmonary Consumption.
- SET XI.—*Seven Vols.*
Naunyn on Cholelithiasis.
Stricker's Histology, Human and Comparative, 3 Vols. (Illustrated).
Selections from the Works of Dr. Duchenne.
Koch's Researches on Wound Infection.
Stokes on Diseases of the Chest.

THERE ARE XXIV. SUCH SETS.

Jas. Swift & Son,

MANUFACTURING OPTICIANS,

Solely appointed to the Army Medical Department, War Office, for the supply of Microscopes.

Patent 4-legged Microscope, with Coarse and Fine Adjustment, Large Stage suitable for Bacteriological work, Flat and Concave Mirrors, $\frac{3}{4}$ " & $\frac{1}{2}$ " Objectives (first quality), one Ocular and Iris Diaphragm. The whole packed in Mahogany Cabinet,

£7 0 0

SPECIAL MICROSCOPES FOR BACTERIOLOGISTS.

Prospectus Free on Application.

81, TOTTENHAM COURT ROAD, W.



Demy 8vo. Fully Illustrated. Price 1s. 6d. net; Post Free 1s. 8d

BRITISH SANATORIA

FOR THE

OPEN-AIR TREATMENT OF TUBERCULOSIS.

[Reprinted with additions and alterations from the "West London Medical Journal."]

N.B.—This book will be found invaluable to Medical Men as well as the general public seeking information on the above subject.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Great Titchfield Street, London, W.

PERSONS desiring to communicate with THE LONDON SCHOOL OF TROPICAL MEDICINE should address The Medical Tutor, London School of Tropical Medicine, Seamen's Hospital, Royal Albert Dock, E., or The Secretary, P. Michelli, Esq., Seamen's Hospital, Greenwich, S.E.

THE JOURNAL OF TROPICAL MEDICINE.

A MONTHLY JOURNAL DEVOTED TO MEDICAL, SURGICAL AND GYNÆCOLOGICAL WORK IN THE TROPICS.

Edited by James Cantlie, M.B., F.R.C.S., and W. J. Simpson, M.D., F.R.C.P.

Published by JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield St., London, W.

Subscription, 17/- per annum, payable in advance.

With Illustrations, 808 pages, crown 8vo, 12s. 6d.

AN INDEX OF MEDICINE:

A Manual for the Use of Senior Students and Others,

BY

SEYMOUR TAYLOR, M.D., F.R.C.P.,

Physician to the West London Hospital.

PRESS OPINIONS.

The Lancet.—"Dr. Seymour Taylor may certainly be congratulated on the success of his labours. He has produced exactly what he desired, and the book may confidently be recommended to those for whom it is intended."

The British Medical Journal.—"As a supplement to the larger standard treatises, and so as a means of codifying the knowledge of the more advanced, it will prove invaluable."

London: SMITH, ELDER & CO.

THE STUDENT'S Laryngology Set of Instruments.

Specially designed to meet the requirements of the Classes held
at the Polyclinic and Medical Graduates' College, London.

THIS Set consists of the following Instruments of best quality, and is supplied either in plain cardboard box or in leather-covered cases as under :—

Head Mirror, with either band or spectacle frames.

3 Laryngeal Mirrors of different sizes, fitting into one metal handle.

1 Post Nasal Mirror, in metal handle.

2 Laryngeal Mirrors, marked "L," in ivory handle. } For Syphilitic Cases

1 Tongue Depressor, marked "L." } (Lues).

1 do. do.

1 Nasal Speculum.

1 Set of 3 Aural Specula.

1 Flexible Probe.

1 Pair of Dressing Forceps.

Price, Complete in Cardboard Box, £2 10s. net, or in leather-covered Case
with Catch, 9s. extra.

Forceps for Peritonsillar Abscess

(Suggested by Dr. StClair Thomson).



THESE Forceps are a slight modification of Lord Lister's Sinus Forceps. Being intended chiefly for use in the Throat and Nose, they have been made with a crank handle, so that the field of operation is not concealed by the surgeon's hand. They will be found particularly useful for opening peritonsillar abscesses. When the abscess is pointing, generally at the upper end of the tonsil, firm pressure with the extremity of the Forceps will readily detect the site of suppuration and with slight increase in force the point can be made to penetrate the abscess easily. In withdrawing them the two blades should be separated as in Hilton's method.

The Forceps are also very useful in removing foreign bodies from the nose.

Price, Nickel-plated, 5s. 6d. each, or with Aseptic Joint, 6s. 6d.

ALLEN & HANBURY'S, Ltd.,

Surgical Instrument Manufacturers,

Surgical Instrument Department : 48, WIGMORE STREET, W.

CITY HOUSE :

INSTRUMENT FACTORY :

PLOUGH COURT, LOMBARD STREET, E.C.

59, WEYMOUTH STREET, W.

LONDON.

The Polyclinic

BEING THE JOURNAL OF THE

Medical Graduates' College London.

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION
OF THE MUSEUM AND LIBRARY COMMITTEE, BY

JONATHAN HUTCHINSON.

COMMITTEE OF CO-OPERATION.

T. CLIFFORD ALLBUTT.
ALFRED GALABIN.
STEPHEN MACKENZIE.
WM. MILLER ORD.

SIR WM. BROADBENT.
J. HUGHLINGS JACKSON.
MALCOLM MORRIS.
C. THEODORE WILLIAMS.

CONTENTS.

| | PAGE |
|--|------|
| LEPROSY IN RELATION TO SOUTH AFRICAN COLONISATION | 193 |
| MARY LAMB'S ILLNESS | 197 |
| MANCHURIA | 200 |
| HEALTH-CONDITIONS IN BULAWAYO | 205 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| PANCREATITIS, WITH ESPECIAL REFERENCE TO CHRONIC PANCREATITIS: | |
| A. W. MAYO ROBSON, F.R.C.S.ENG. | 207 |
| THE "CACODYLIC MEDICATION": | |
| WM. EWART, M.D.CANTAB., F.R.C.P. | 220 |
| LECTURES ON RESUSCITATION FROM DROWNING, &C.: | |
| DR. BOWLES | 227 |
| NOTES OF CASES DEMONSTRATED IN CONSULTATIONS: | |
| MEDICAL CASES: DR. SEYMOUR TAYLOR | 234 |
| CASES WITH COMMENTS FROM THE SURGICAL CLINIC: MR. HUTCHINSON ... | 238 |
| REPORTS OF MEETINGS OF COMMITTEES OF INVESTIGATION | 243 |
| RECENT EXPERIMENTS AS TO MALARIA | 246 |
| COLLEGE NOTES, BY THE DEAN | 250 |
| DEFINITIONS OF WORDS AND TERMS | 254 |
| CORRESPONDENCE AND ANSWERS | 256 |

Published by

JOHN BALE, SONS & DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, LONDON, W.

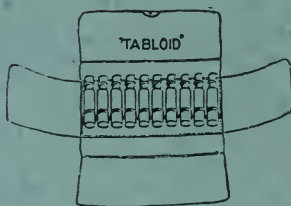
Price: One Shilling.

TRADE
MARK

'TABLOID' BRAND

Medicine Cases

FOR THE PHYSICIAN'S
POCKET, CYCLE OR CARRIAGE.



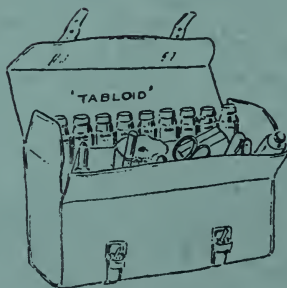
'Tabloid' Pocket Case.

WHILST 'Tabloid' Equipments have been undergoing their severest tests and achieving their greatest triumphs as the outfits of all recent important military and exploring expeditions, their convenience, compactness and suitability for every-day practice at home have been firmly established. A 'Tabloid' Medicine Case in the pocket or carriage or on the cycle provides supplies of reliable, accurately-dosed, emergency medicines independent of time or place

Fully illustrated list sent on request.

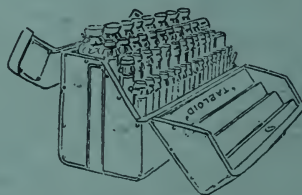
Burroughs Wellcome & Co.,

Snow Hill Buildings, LONDON, and
108, Pitt Street SYDNEY, N.S.W.



Physician's Cycle Handle-Bar
'Tabloid' Medicine Case.

[COPYRIGHT]



'Tabloid' Medicine Carriage Case

J 120

SPECIAL PLAGUE NUMBER.

THE PRACTITIONER.

A JOURNAL OF PRACTICAL MEDICINE.

EDITED BY

MALCOLM MORRIS.

The OCTOBER PART, Price 2/-, contains:—

THE MONTH:—

The Plague.
A Source of Danger.
Over-security not Justified.
The Good Example of Glasgow.
The Port of London.
Division of Sanitary Authority in
London.

Inspection of Lodging-houses and
Shelters.
The Notification of Plague.
The Medical Profession and the
Election.
New Medical Candidates.
The Hospitals Commission.

Ave Culex Imperator.

ORIGINAL COMMUNICATIONS:—

Symptoms, Pathology, and Treatment of Bubonic Plague. By James Cantlie, M.A., M.B., F.R.C.S. Eng., D.P.H. Lond. (*Illustrated.*)

Recent Cases of Plague in London. By Patrick Manson, C.M.G., M.D., F.R.S.

Plague: Its Bacteriology, Bacteriological Diagnosis, Dissemination, Prophylaxis, and Serum-Therapy. By R. Tanner Hewlett, M.D., M.R.C.P., D.P.H. (*Illustrated.*)

Plague in English Seaports: Some Observations and Practical Hints. By David C. Rees, M.R.C.S., L.R.C.P.

Circumstances Connected with the Occurrence of Cases of Plague: The Preventive Aspects. By A. K. Chalmers, M.D., D.P.H. Camb.

Port of London: The Prevention of Plague. By W. Collingridge, M.A., M.D.

A MEDICO-LITERARY CAUSERIE:—

Pictures of Plague in the Past. (*Illustrated.*)

A REVIEW OF THE MEDICAL SCIENCES:—

Diseases of the Respiratory Organs. By J. J. Perkins, M.A., M.B., M.R.C.P.

Gynæcology. By John Phillips, M.A., M.D. Cantab., F.R.C.P. (*Illustrated.*)

REVIEWS OF BOOKS. (*Illustrated.*) LITERARY GOSSIP.

PRACTICAL NOTES. A MEDICAL CALENDAR.

Annual Subscription, 21s., post free.

CASSELL & Co., Ltd., London, Paris, New York & Melbourne.

THE MEDICAL GRADUATES' COLLEGE & POLYCLINIC

22, CHENIES STREET, LONDON, W.C.



Vice-Patrons:

THE LORD IVEAGH, K.P., LL.D.
THE RIGHT HON. LORD STRATHCONA AND MOUNT ROYAL, G.C.M.G.
THE RIGHT HON. A. J. BALFOUR, M.P., LL.D.
THE RIGHT HON. LORD AVEBURY, F.R.S.

President:

Sir Wm. H. Broadbent, Bart., LL.D., F.R.S.

Vice-Presidents:

Prof. Clifford Allbutt, LL.D., F.R.S.
Sir John Banks, K.C.B., M.D.
Sir James Crichton Browne, LL.D., F.R.S., M.D.
Thomas Bryant, F.R.C.S.
Sir Joseph Fayrer, K.C.S.I., F.R.S., M.D.
Sir Wm. T. Gairdner, K.C.B., LL.D., M.D.
Jonathan Hutchinson, LL.D., F.R.S.
J. Hughlings Jackson, LL.D., F.R.S.

J. Fletcher Little, M.B., M.R.C.P.
Col. Kenneth McLeod, LL.D., M.D.
Prof. William Osler, LL.D., M.D.
Sir John Watt Reid, K.C.B., LL.D., M.D.
Sir John Burdon Sanderson, Bart., LL.D., F.R.S.
Sir John Batty Tuke, M.P., M.D.
Sir Samuel Wilks, Bart., LL.D., F.R.S.

Treasurer: Chas. Theodore Williams, M.D., F.R.C.P.

Dean: Guthrie Rankin, M.D., M.R.C.P.

Council:

Chairman: Jonathan Hutchinson, LL.D., F.R.S.

Vice-Chairman: Malcolm A. Morris, F.R.C.S.

James Berry, B.S., F.R.C.S.
Robt. Bowles, M.D., F.R.C.P.
James Cantlie, B.S., F.R.C.S.
Prof. Crookshank, M.B.
Alderman Crosby, M.D., F.R.C.S.
Alfred L. Galabin, M.D., F.R.C.P.
James F. Goodhart, M.D., F.R.C.P.

Alfred P. Hillier, M.D.
Constantine Holman, M.D.
Boyd Joll, M.B.
Sir William Kynsey, F.R.C.P.
Stephen Mackenzie, M.D., F.R.C.P.
Patrick Manson, F.R.S., LL.D., M.D.

George Oliver, M.D., F.R.C.P.
W. Miller Ord, M.D., F.R.C.P.
Solomon Smith, M.D., M.R.C.P.
James Taylor, M.D., F.R.C.P.
Seymour Taylor, M.D., F.R.C.P.
StClair Thomson, M.D., F.R.C.S.

Medical Superintendent:

A. E. Hayward Finch, F.R.C.S.

The Electrical Standardizing, Testing and Training Institution.

Principal:

HUGH ERAT HARRISON, B.Sc., M.I.E.E.

Gentlemen's Sons Prepared for the ELECTRICAL ENGINEERING PROFESSION.

The training is thoroughly theoretical and practical, the Institution being associated with most of the leading Electrical Firms and Central Electric Lighting Stations, for the express purpose of affording its Students a proper practical insight into their future profession. Prospectus on application to the Secretary.

INSPECTING AND TESTING DEPARTMENT.

The Institution undertakes the inspection and test of electrical plant, and certifies the same either on behalf of Manufacturers or Buyers. Private testing rooms, supplied with current and apparatus, are let to Experimenters. Terms on application to the Secretary.

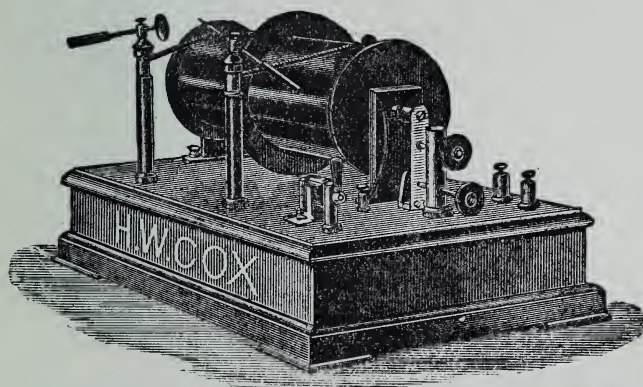
FARADAY HOUSE,
CHARING CROSS ROAD, LONDON, W.C.

Telegraphic Address:—"STANDARDIZING, LONDON."

X-RAYS APPARATUS

Of the Highest Quality and Finish only.

BUY DIRECT FROM THE MAKERS.



As supplied by us to H.M. Government for use in South Africa, The "Princess of Wales" Hospital Ship, Scottish National Red Cross Hospital, The Welsh Hospital, The Yeomanry Hospital, Medical Men, Hospitals, Chemists, and X-Ray Workers in all parts of the World. Our Apparatus gives the very best results, and we guarantee all our coils against breaking down.

Our price list, with simple instructions how to set about work, will be sent post free to readers of the "Polyclinic."

HARRY W. COX, Ltd.,

Manufacturing Electricians,

10, 11, and 28, CURSITOR STREET, CHANCERY LANE, W.C.

SPECIAL DARK ROOM FOR DEMONSTRATIONS.

J. H. MONTAGUE,

SURGICAL INSTRUMENT MAKER AND CUTLER.

By Appointment to—
The Honourable Council of
India,
St. George's Hospital,
Westminster Hospital, &c.

TELEGRAPHIC ADDRESS—
"MASTOID, LONDON."

FLUX'S CHLOROFORM INHALER.

For the safe
administration
of Chloroform.

Vide the *Lancet*, Feb. 3rd, 1900.

Price, complete in Case,
£1 15 0

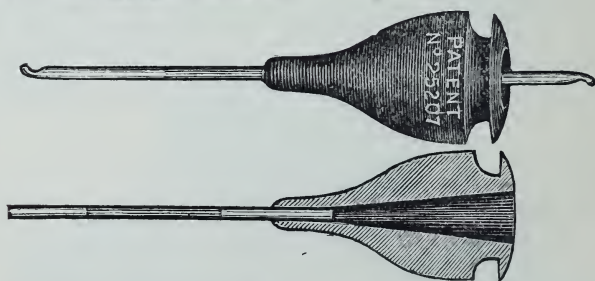


PATENT VACCINE EXPELLER.

Price 1/6 each,
or, 16/- per doz.

To meet the requirements
of the
Local Government Board.

Can be thoroughly
Sterilised.



PATENT ATMO-THERME STERILISER,

Made in Tin, 14 by 8 Price, £2 10 0

" Copper, N.P., 14 by 8 " £5 5 0

Any size made to order

CARTER BRAINE'S IMPROVED ORMSBY'S INHALER,

With Attachment for the Administration of A. C. E. Mixture and Chloroform.

Price Complete, Nickel Plated £3 3 0

COMPLETE OUTFITS for the PRODUCTION of RONTGEN'S "X" RAYS.

Skiagraphs Taken at any Time, or by Appointment.

101, NEW BOND STREET, LONDON, W.

MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CONSULTATIONS AND LECTURES

From **SEPTEMBER** to **DECEMBER, 1900.**

Consultations at 4 p.m.

* Clinical Lectures at 5 p.m.

SPECIAL COURSES OF LECTURES AT 5.15 P.M.

| MONDAYS. (Skin) | TUESDAYS. (Medical) | WEDNESDAYS. (Various) | THURSDAYS. (Surgical) | FRIDAYS. (Eye, Ear, Nose, and Throat.) |
|--------------------------------------|---------------------------------------|--|--------------------------------|--|
| September 3 College opens | September 4 Dr. W. Ewart | September 5 <i>Surgical Cons.</i> Mr. James Berry | September 6 Mr. Hutchinson | September 7 Mr. J. Griffith |
| September 10 Mr. Hutchinson | September 11 Dr. Seymour Taylor | *September 12 <i>Clinical Lecture.</i> Dr. Byrom Bramwell | September 13 Mr. Hutchinson | September 14 Dr. Dundas Grant |
| September 17 Dr. A. Whitfield | September 18 Dr. James Taylor | September 19 <i>Cons. Pediatrics.</i> Dr. G. F. Still | September 20 Mr. Hutchinson | September 21 Mr. N. Maclehorse |
| September 24 Mr. W. Anderson | September 25 Dr. C. Theo. Williams | *September 26 <i>Clinical Lecture.</i> Dr. A. E. Sansom | September 27 Mr. Hutchinson | September 28 Dr. St. Clair Thomson |
| October 1 Dr. T. Colcott Fox | October 2 Dr. J. E. Squire | October 3 <i>Medical Cons.</i> Dr. Alfred Hillier | October 4 Mr. Hutchinson | October 5 Mr. R. Lake |
| October 8 Dr. Jas. Galloway | October 9 Dr. James Taylor | *October 10 <i>Clinical Lecture.</i> Sir Wm. Gowers | October 11 Mr. Hutchinson | October 12 Mr. Treacher Collins |
| October 15 Mr. Malcolm Morris | October 16 Sir Wm. Broadbent | October 17 <i>Surgical Cons.</i> Mr. J. Cantlie | October 18 Mr. Hutchinson | October 19 Dr. St. Clair Thomson |
| October 22 Dr. T. Colcott Fox | October 23 Dr. Harry Campbell | *October 24th <i>Clinical Lecture.</i> Mr. W. H. A. Jacobson | October 25 Mr. Hutchinson | October 26 Dr. Dundas Grant |
| October 29 Dr. J. F. Payne | October 30 Sir Wm. Broadbent | October 31 <i>Surgical Cons.</i> Mr. Reg'd. Harrison | November 1 Mr. Hutchinson | November 2 Mr. Holmes Spicer |
| November 5 Dr. J. J. Pringle | November 6 Dr. R. L. Bowles | *November 7 <i>Clinical Lecture.</i> Dr. Chris. Childs | November 8 Mr. Hutchinson | November 9 Dr. Herbert Tilley |
| November 12 Mr. Malcolm Morris | November 13 Dr. W. Ewart | November 14 <i>Surgical Cons.</i> Mr. Johnson Smith | November 15 Mr. Hutchinson | November 16 Dr. Dundas Grant |
| November 19 Dr. J. F. Payne | November 20 Dr. S. J. Sharkey | *November 21 <i>Clinical Lecture.</i> Prof. Alfred Carter | November 22 Mr. Hutchinson | November 23 Mr. Holmes Spicer |
| November 26 Dr. Radcliffe Crocker | November 27 Dr. Seymour Taylor | November 28 <i>Cons. Pediatrics.</i> Dr. W. B. Cheville | November 29 Mr. Hutchinson | November 30 Dr. St. Clair Thomson |
| December 3 Mr. W. Anderson | December 4 Dr. Guthrie Rankin | *December 5 <i>Clinical Lecture</i> Sir Hector Cameron | December 6 Mr. Hutchinson | December 7 Mr. R. Lake |
| December 10 Mr. Malcolm Morris | December 11 Dr. Harry Campbell | December 12 <i>Surgical Cons.</i> Mr. B. W. Roughton | December 13 Mr. Hutchinson | December 14 Mr. Treacher Collins |
| December 17 Dr. Jas. Galloway | December 18 Dr. C. Theo. Williams | *December 19 <i>Clinical Lecture.</i> Dr. Burney Yeo | December 20 Mr. Hutchinson | December 21 Dr. Herbert Tilley |

October 12th, 19th, and 26th. Mr. HAYWARD PINCH—"The Clinical Examination of the Blood."

November 2nd, 9th, and 16th. Mr. P. J. FREYER—"Some Practical Points in the Surgery of the Urinary Organs."

December 3rd, 10th, and 17th. Dr. STCLAIR THOMSON—"The Surgical Anatomy of the Nose and Accessory Sinuses, including Nasal Suppuration."

GUTHRIE RANKIN, M.D., *Dean.*

A. E. HAYWARD PINCH, F.R.C.S., *Medical Superintendent.*

DIARY FOR OCTOBER.

APPOINTMENTS AT THE POLYCLINIC.

Consultations at 4 p.m. Clinical Lectures at 5 p.m.

| | | | | |
|----|-----------|-----|-------------------|------------------------|
| 1 | Monday | ... | Cons. (Skin). | Dr. T. Colcott Fox. |
| 2 | Tuesday | ... | Cons. (Med.). | Dr. J. E. Squire. |
| 3 | Wednesday | ... | Cons. (Med.). | Dr. Alfred Hillier. |
| 4 | Thursday | ... | Cons. (Surg.). | Mr. Hutchinson. |
| 5 | Friday | ... | Cons. (Ear). | Mr. Lake. |
| 6 | Saturday | ... | | |
| 7 | SUNDAY | ... | | |
| 8 | Monday | ... | Cons. (Skin). | Dr. James Galloway. |
| 9 | Tuesday | ... | Cons. (Med.). | Dr. Jas. Taylor. |
| 10 | Wednesday | ... | Clinical Lecture. | Sir William Gowers. |
| 11 | Thursday | ... | Cons. (Surg.). | Mr. Hutchinson. |
| 12 | Friday | ... | Cons. (Eye). | Mr. Treacher Collins. |
| 13 | Saturday | ... | | |
| 14 | SUNDAY | ... | | |
| 15 | Monday | ... | Cons. (Skin). | Mr. Malcolm Morris. |
| 16 | Tuesday | ... | Cons. (Med.). | Sir William Broadbent. |
| 17 | Wednesday | ... | Cons. (Surg.). | Mr. Cantlie. |
| 18 | Thursday | ... | Cons. (Surg.). | Mr. Hutchinson. |
| 19 | Friday | ... | Cons. (Throat). | Dr. StClair Thomson. |
| 20 | Saturday | ... | | |
| 21 | SUNDAY | ... | | |
| 22 | Monday | ... | Cons. (Skin). | Dr. T. Colcott Fox. |
| 23 | Tuesday | ... | Cons. (Med.). | Dr. Harry Campbell. |
| 24 | Wednesday | ... | Clinical Lecture. | Mr. W. H. A. Jacobson. |
| 25 | Thursday | ... | Cons. (Surg.). | Mr. Hutchinson. |
| 26 | Friday | ... | Cons. (Ear). | Dr. J. Dundas Grant. |
| 27 | Saturday | ... | | |
| 28 | SUNDAY | ... | | |
| 29 | Monday | ... | Cons. (Skin). | Dr. J. F. Payne. |
| 30 | Tuesday | ... | Cons. (Med.). | Sir William Broadbent. |
| 31 | Wednesday | ... | Cons. (Surg.). | Mr. Reginald Harrison. |

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

MICHAELMAS TERM, 1900.

PRACTICAL CLASSES.

| | | |
|--|---|---|
| Applied Anatomy (Medical and Surgical), Physical Diagnosis | { | Seymour Taylor, M.D., F.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S. |
| Clinical Examination of the Nervous System | { | James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P. |
| Practical Ophthalmology: the use of the Ophthalmoscope and Refraction | { | E. Treacher Collins, F.R.C.S. W. Holmes Spicer, M.B., F.R.C.S. John Griffith, F.R.C.S. |
| Practical Otology | { | J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S. |
| Practical Rhinology and Laryngology | { | StClair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P. |
| The Application of the Röntgen Rays | | F. Harrison Low, M.B. |
| Clinical Microscopy | | A. E. Hayward Pinch, F.R.C.S. |

COURSES OF LECTURES.

| | | |
|--|-----|------------------------------------|
| General Ophthalmology... .. | ... | R. Marcus Gunn, M.B., F.R.C.S. |
| Lectures and Demonstrations on Diseases of the Skin | ... | Phineas S. Abraham, M.D., F.R.C.S. |
| Administration of Anæsthetics... .. | ... | J. F. W. Silk, M.D. |
| Diseases of Children | ... | G. F. Still, M.D., M.R.C.P. |

CLASSES IN ASSOCIATION WITH THE COLLEGE.

| | | |
|----------------------------------|-----|-----------------------------------|
| Practical Bacteriology | ... | Professor Crookshank, M.B. |
| Mental Diseases | ... | Maurice Craig, M.D., M.R.C.P. |
| Hygiene and Public Health | ... | A. Wynter Blyth, M.R.C.S., F.C.S. |

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, W.C.

MICHAELMAS TERM, 1900.

Commenced Monday, Sept. 17th ; ends Friday, Oct. 26th.

CLINICAL LECTURES will be given on alternate Wednesdays at 5 P.M., commencing Wednesday, Oct. 10th.

CLINICAL CONSULTATIONS AT 4 P.M.

Mondays (Skin); Tuesdays (Medical); Wednesdays (Various); Thursdays (Surgical); Fridays (Eye, Ear, Throat, and Nose).

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis. Tuesdays and Thursdays, at 6 P.M. Commenced Tuesday, Sept. 18th. Fee £2 2s. Dr. J. E. Squire and Mr. A. Carless.

Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M. Commenced Friday, Sept. 21st. Fee, £2 2s. Dr. Harry Campbell.

Practical Application of Röntgen Rays. Thursdays, 3 P.M. Commenced Thursday, Sept. 20th. Fee, £2 2s. Dr. Harrison Low.

Practical Ophthalmology: the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M. Commences Friday, Sept. 21st. Fee, £2 2s. Mr. John Griffith.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M. Commenced Wednesday, Sept. 19th. Fee, £2 2s. Dr. W. Jobson Horne.

Practical Otology. Mondays, 5 to 7 P.M. Commenced Monday, Sept. 17th. Fee £2 2s. Mr. R. Lake.

Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30 P.M. Commenced Monday, Sept. 17th. Fee £2 2s. Mr. Hayward Pinch. Composition fee for any three of above courses, £5 5s.

LECTURES.

(Conditional upon a minimum number of entries being received.)

Diseases of the Eye. Mr. Marcus Gunn.

Diseases of the Skin. Dr. Phineas Abraham.

Administration of Anæsthetics. Dr. Silk.

Diseases of Children. Dr. G. F. Still.

Fee for any one course of Six Lectures, £1 1s.

LABORATORY AND CLINICAL CLASSES.

Practical Bacteriology. Daily, 10 A.M. to 1 P.M., and 2 to 5 P.M. Fee, £5 5s. Professor Crookshank.

Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee, £2 2s. Professor Crookshank.

Hygiene and Public Health. Fee, £2 2s. Mr. Wynter Blyth.

Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.

Morbid Conditions of the Urine and their Clinical Significance. Fee, £2 2s.

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, Gower Street, W.C.

Extra classes may be formed to suit the convenience of practitioners unable to attend those already provided.

APPLICATION FOR MEMBERSHIP.

Date

To THE DEAN OF THE

MEDICAL GRADUATES' COLLEGE AND "Polyclinic,"
20, CHENIES STREET, W.C.

Dear Sir,

I desire to join the "Polyclinic" as a Member. When I hear
Subscriber. from you that my application has been approved by the Council, I shall
send you a cheque for my first year's Subscription.

This application is
supported by the
following Members
of the College:

Name

Qualification

Address

Subscription to Journal Order Form.

To THE PUBLISHERS OF THE "Polyclinic,"

MESSRS. JOHN BALE, SONS AND DANIELSSON, LTD.,

83-89, GT. TITCHFIELD STREET,

LONDON, W.

Please forward to me to the undermentioned address.....

Copies of the "Polyclinic" for the coming year (1900). I enclose Postal
Order for Twelve Shillings and Sixpence.

Name

Address

PLASMON

USES IN DISEASE.

This Natural Milk Proteid, Highly Nutritious, Easily Digested, and Readily Assimilated Food, is intended for Infants and Adults whose digestive functions are impaired by illness or senile decay. Rich in Albumins and Phosphates of Lime, Iron, Sodium and Potassium, it forms an ideal food for the repair of Tissues—whether, Muscle, Nerve or Bone.

In the Dietary of Typhoid and other Fever Patients, Plasmon takes a very high place and is preferred to milk by many. It does not form a heavy clot like milk, and the green appearance of the stools soon disappears.

It does not in any way increase the temperature; by maintaining the Nitrogen equilibrium it has the reverse effect.

In the Treatment of Consumption, Plasmon will be found to be an ideal food by reason of its highly nitrogenous value and its digestible nature. It does not nauseate the patient, as 3 or 4 lbs. of beef steak, or 6 to 8 pints of milk per day would—one tea-spoonful of Plasmon being equivalent to 4 ounces of beef steak, or $1\frac{1}{2}$ pints of milk, in nutrient value.

In Strumous, Marasmic, and other Tubercular affections, Plasmon forms a food that produces most favourable results. Very marked effects are obtained in Rickets, and other Bone disorders, the Salts of Milk supplying all that is necessary for the development of healthy bone tissue.

In cases of Peritonitis and such like abdominal affections, Plasmon will be found very useful, as it is almost entirely absorbed, and causes no irritation along the alimentary tract. In cases of abdominal surgery where absolute rest is required for the bowels, Plasmon forms an ideal diet.

In Neurasthenia and cases of Multiple Neuritis, Plasmon, as a Food and Therapeutic Agent, is held in very high esteem. Plasmon has very powerful action on the Nerve Tissues, supplying the Phosphorus necessary for the building up of healthy nerve cells. It is perfectly soluble, forming a neutral solution.

*SAMPLES, together with MEDICAL EVIDENCE & MEDICAL PRESS REPORTS,
Free of Charge, sent to Medical Men and Nurses only.*

PRICES: Plasmon Granulated Powder—

| | | | | | | |
|------------|----|----|----|----|----|-----------------|
| Small size | .. | .. | .. | .. | .. | 9d. per packet. |
| Medium „ | .. | .. | .. | .. | .. | 1s. 4d. „ |
| Large „ | .. | .. | .. | .. | .. | 2s. 6d. „ |

The Plasmon Syndicate, Ltd.,
56, Duke Street, Grosvenor Square, LONDON, W.

Concise yet comprehensive summaries of all in periodical literature important to the practitioner. Facts, not mere opinions, characterise the "Review," instead of the commonplace remarks and indiscriminate and useless notices of crude and unproved views which constitute many so called "Epitomes."

The Medical Review

(MEDICAL AND SURGICAL REVIEW OF REVIEWS.)

AN INDEXED AND ILLUSTRATED
MONTHLY RECORD OF ALL THAT IS IMPORTANT TO THE PRACTITIONER IN THE
MEDICAL PERIODICALS IN THE WORLD.

PRINTED IN LARGE CLEAR TYPE, ON SUPERFINE PAPER.

Subscription £1 per annum, post free to any part of the world.

By the suppression of all unessential matter, a paper written with any definite object—and such alone is valuable—can generally be compressed into a comparatively brief report, and yet remain a clear and readable account of the subject, so that nothing of importance is lost, and often, in lucidity, much is gained. Merely to mention a few of the leading features of an article serves no useful purpose.

"... A great boon to the profession all over the world. . . I applaud not only your scheme, but the manner of its execution. . ."—JONATHAN HUTCHINSON, LL.D., F.R.S., Ex-President of the Royal College of Surgeons, England.

"Extremely useful to the busy practitioner."—*Lancet*.

"... I think you are about to fill a very great want. . ."—T. CLIFFORD ALLBUTT, M.A., M.D., F.R.C.P., F.R.S., Regius Prof. of Physic, Cambridge University.

"... It would be impossible for such a journal not to take at once a first place. . ."—*Birmingham Medical Review*.

"... Of great value to the general practitioner, and to teachers and authors. . ."—BYROM BRAMWELL, M.D., F.R.C.P. Edin.

"Destined to the greatest and legitimate success. . . Well edited. Giving an exact account of all of importance in science and medical practice."—*Journal des Practiciens*.

"The 'Review' brings me into touch with methods and ideas which I could not possibly have otherwise obtained. . . No surgeon can afford to do without such an excellent index to scientific progress."—J. O'CONOR, M.A., M.D., Senior Medical Officer, British Hospital, Buenos Ayres.

IMPORTANT TO NEW SUBSCRIBERS.

BACK NUMBERS.

The attention of new subscribers is called to the desirability of applying for Vols. I. and II. of the "REVIEW" before they are out of print.

As the important facts recorded in the "REVIEW" are not presented as isolated contributions only, but as collated records, the bound volumes present, in a unique manner, the definite progress of medical science, and render all that is important to the practitioner in the current medical periodicals readily accessible.

Already one of the parts has had to be reprinted, and now only a limited number of Vol. II. is available for new subscribers. The first 500 new subscribers to the "REVIEW" for this current year, who purchase Vol. II. will each be entitled to a bound copy of Vol. I. (Nos. 1, 2 and 3) free of charge.

The price for Vol. II., crown 4to, cloth, is 21/- net.

All communications to be addressed to the SECRETARY, Cheques and Postal Orders should be made payable to THE MEDICAL AND SURGICAL "REVIEW OF REVIEWS," LIMITED, 12, Norfolk Street, Strand, London, W.C., and crossed "BROWN, JANSON & Co."

NEW SYDENHAM SOCIETY.

SALE OF SURPLUS VOLUMES.

IN order to reduce its Stock-in-hand, the Society is now offering many of the past Volumes at almost nominal cost. Among them are those of Graves, Niemeyer, Stokes, Trousseau (Vols. i., iv., v.), Charcot, Marie, Spiegelberg, Pozzi, and many others. The Volumes have been re-arranged in Guinea Sets. In some instances as many as Eight Volumes may be obtained for One Guinea. Full Catalogues may be obtained from

MR. H. K. LEWIS, 136, Gower Street, W.C.

The following are the Contents of some of the Sets :—

SET I.—Three Vols.

Two Monographs on Malaria and the Parasites of Malarial Fevers
Laveran on Paludism.
Selected Monographs, Vol. 121, on Malaria, &c.

SET III.—Five Vols.

Binz's Lectures on Pharmacology, 2 Vols.
Naunyn on Cholelithiasis.
Ewald's Disorders of Digestive Organs, 2 Vols.

SET V.—Eight Vols.

The Works of Sir William Gull, 2 Vols.
The Collected Works of Dr. Addison.
Latham's Works, 2 Vols.
Selections from the Works of Colles.
Warburton Begbie's Works.
Graves's Clinical Medicine, 2 Vols.

SET VII.—Six Vols.

Selected Monographs on Dermatology (Unna, Nielsen, Duhring, Bronson, Blanc, Berger, Prince-Morrow).
Essays on Acromegaly (Pierre Marie and Souza Leite).
The Works of Sir William Gull, 2 Vols.
Monographs and Lectures from German Sources, Series iii.
Selected Monographs, Vol. 110.

SET VIII.—Seven Vols.

Billroth's Clinical Surgery (Illustrated).
Essays on Micro-Parasites in Disease. Selected by Watson Cheyne (Illustrated).
Monographs and Lectures from German Sources, Series iii., Vol. 148.
Essays on Acromegaly (Pierre Marie and Souza Leite).
Memoirs on Diphtheria.
Lancereaux's Syphilis, 2 Vols.

SET X.—Eight Vols.

Selected Lectures and Papers from Foreign Sources, Vol. 161.
Naunyn on Cholelithiasis.
Hebra's Diseases of the Skin, Vols. ii., iii., iv. and v.
Griesinger on Mental Pathology.
Niemeyer's Lectures on Pulmonary Consumption.

SET XI.—Seven Vols.

Naunyn on Cholelithiasis.
Stricker's Histology, Human and Comparative, 3 Vols. (Illustrated).
Selections from the Works of Dr. Duchenne.
Koch's Researches on Wound Infection.
Stokes on Diseases of the Chest.

THERE ARE XXIV. SUCH SETS.

Medium 8vo. Cloth lettered. 15s. net. Post Free 16s.

A HANDBOOK OF THE GNATS OR MOSQUITOES.

MAINLY intended for the Use of Students of Tropical Medicine giving the Anatomy and Life History of the Culicidæ, with Tables and a Compilation of the descriptions of over 240 species, and Illustrated with one folding and seven full-page plates, and numerous figures in the text.

By MAJOR GEO. M. GILES, I.M.S., M.B.Lond., F.R.C.S.,

Formerly Naturalist to the Indian Marine Survey.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Gt. Titchfield Street, W.

Demy 8vo. Fully Illustrated. Price 1s. 6d. net; Post Free 1s. 8d.

BRITISH SANATORIA

FOR THE

OPEN-AIR TREATMENT OF TUBERCULOSIS.

[Reprinted with additions and alterations from the "West London Medical Journal."]

N.B.—This book will be found invaluable to Medical Men as well as the general public seeking information on the above subject.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Great Titchfield Street, London, W.

PERSONS desiring to communicate with THE LONDON SCHOOL OF TROPICAL MEDICINE should address The Medical Tutor, London School of Tropical Medicine, Seamen's Hospital, Royal Albert Dock, E., or The Secretary, P. Michelli, Esq., Seamen's Hospital, Greenwich, S.E.

THE JOURNAL OF TROPICAL MEDICINE.

A MONTHLY JOURNAL DEVOTED TO MEDICAL, SURGICAL AND GYNÆCOLOGICAL WORK IN THE TROPICS.

Edited by James Cantlie, M.B., F.R.C.S., and W. J. Simpson, M.D., F.R.C.P.

Published by JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Great Titchfield St., London, W.

Subscription, 17/- per annum, payable in advance.

With Illustrations, 808 pages, crown 8vo, 12s. 6d.

AN INDEX OF MEDICINE:

A Manual for the Use of Senior Students and Others,

BY

SEYMOUR TAYLOR, M.D., F.R.C.P.,

Physician to the West London Hospital.

PRESS OPINIONS.

The Lancet.—"Dr. Seymour Taylor may certainly be congratulated on the success of his labours. He has produced exactly what he desired, and the book may confidently be recommended to those for whom it is intended."

The British Medical Journal.—"As a supplement to the larger standard treatises, and so as a means of codifying the knowledge of the more advanced, it will prove invaluable."

London: SMITH, ELDER & CO.

THE STUDENT'S Laryngology Set of Instruments.

Specially designed to meet the requirements of the Classes held
at the Polyclinic and Medical Graduates' College, London.

THIS Set consists of the following Instruments of best quality, and is supplied either in plain cardboard box or in leather-covered cases as under :—

- Head Mirror, with either band or spectacle frames.
- 3 Laryngeal Mirrors of different sizes, fitting into one metal handle.
- 1 Post Nasal Mirror, in metal handle.
- 2 Laryngeal Mirrors, marked "L," in ivory handle. } For Syphilitic Cases
- 1 Tongue Depressor, marked "L." } (Lues).
- 1 do. do.
- 1 Nasal Speculum.
- 1 Set of 3 Aural Specula.
- 1 Flexible Probe.
- 1 Pair of Dressing Forceps.

Price, Complete in Cardboard Box, £2 10s. net, or in leather-covered Case
with Catch, 9s. extra.

Forceps for Peritonsillar Abscess

(Suggested by Dr. StClair Thomson).



THESE Forceps are a slight modification of Lord Lister's Sinus Forceps. Being intended chiefly for use in the Throat and Nose, they have been made with a crank handle, so that the field of operation is not concealed by the surgeon's hand. They will be found particularly useful for opening peritonsillar abscesses. When the abscess is pointing, generally at the upper end of the tonsil, firm pressure with the extremity of the Forceps will readily detect the site of suppuration and with slight increase in force the point can be made to penetrate the abscess easily. In withdrawing them the two blades should be separated as in Hilton's method.

The Forceps are also very useful in removing foreign bodies from the nose.

Price, Nickel-plated, 5s. 6d. each, or with Aseptic Joint, 6s. 6d.

ALLEN & HANBURY'S, Ltd.,

Surgical Instrument Manufacturers,

Surgical Instrument Department : 48, WIGMORE STREET, W.

CITY HOUSE :

PLOUGH COURT, LOMBARD STREET, E.C.

INSTRUMENT FACTORY :

59, WEYMOUTH STREET, W.

LONDON.

JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield Street, Oxford Street, W

The Polyclinic

BEING THE JOURNAL OF THE

Medical Graduates' College.

London.

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION
OF THE MUSEUM AND LIBRARY COMMITTEE, BY

JONATHAN HUTCHINSON.

COMMITTEE OF CO-OPERATION.

T. CLIFFORD ALLBUTT.
ALFRED GALABIN.
STEPHEN MACKENZIE.
WM. MILLER ORD.

SIR WM. BROADBENT.
J. HUGHLINGS JACKSON.
MALCOLM MORRIS.
C. THEODORE WILLIAMS.

CONTENTS.

| | PAGE |
|--|------|
| IMPERIAL MEDICINE | 257 |
| THE FIJIS | 261 |
| HAIRY MEN | 264 |
| MEMORANDA AS TO THE AINOS | 265 |
| RACIAL TENDENCY TO FATTEN | 265 |
| THE CHINESE AND THE MONGOLS... .. | 266 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| ABSTRACT OF LECTURE ON THE DIAGNOSIS OF EPILEPSY: | |
| SIR W. R. GOWERS, F.R.S. | 267 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| JONATHAN HUTCHINSON, F.R.S. | 270 |
| LECTURES ON RESUSCITATION FROM DROWNING, &c.: | |
| DR. BOWLES | 275 |
| NOTES OF CASES DEMONSTRATED IN CONSULTATIONS: | |
| MEDICAL CASES: DR. GOODHART AND DR. SHARKEY | 283 |
| OPHTHALMIC CASES: MR. TREACHER COLLINS | 285 |
| CASES WITH COMMENTS FROM THE SURGICAL CLINIC: MR. HUTCHINSON | 287 |
| LARYNGOLOGY AND OTOTOLOGY: STCLAIR THOMSON | 290 |
| REVIEWS AND NOTICES OF BOOKS:.. | 293 |
| COLLEGE NOTES, BY THE DEAN | 297 |
| CATALOGUE-COMPANION TO THE MUSEUM | 301 |
| CORRESPONDENCE AND ANSWERS | 309 |

Published by

JOHN BALE, SONS & DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, LONDON, W.

Price: One Shilling.



KEPLER

MALT EXTRACT

"BY FAR THE BEST"

MEDICAL TIMES



**BURROUGHS WELLCOME
& CO**

COPYRIGHT

1900

ABDOMINAL SURGERY.

THE PRACTITIONER.

A JOURNAL OF PRACTICAL MEDICINE.

EDITED BY

MALCOLM MORRIS.

The **NOVEMBER PART**, Price 2/-, contains:—

ORIGINAL COMMUNICATIONS:—

THE SURGERY OF THE STOMACH. By Albert Carless, M.S.Lond., F.R.C.S.

THE PRACTITIONER'S DUTY IN THE TREATMENT OF ACUTE INTESTINAL OBSTRUCTION. By A. Ernest Maylard, B.S., M.B.Lond., F.F.P.S.Glas.

APPENDICITIS. By Herbert W. Allingham, F.R.C.S.

HERNIA. By B. G. A. Moynihan, M.S.Lond., F.R.C.S. (*Illustrated.*)

THE SURGERY OF THE LIVER, GALL BLADDER, AND BILIARY PASSAGES. By James Swain, M.S., M.D.Lond., F.R.C.S.Eng.

THE MONTH:—

Sir Henry Acland.

The Preliminary Education of the Doctor.

A Counterblast to Classics.

Celtic as a Substitute for Classics.

The Future of Christian Science.

Medical M.P.'s.

The Doctor in Politics.

The Prevention of Consumption.

A Cassandra Voice on the Crusade against Consumption.

MEDICAL MEN OF LETTERS:—

Oliver Goldsmith. (*With Portrait.*)

PUBLIC HEALTH:—

Ought cases of Measles to be Compulsorily Notified?

A REVIEW OF THE MEDICAL SCIENCES:—

Diseases of the Circulatory System and Allied Disorders. By Raymond Crawford, M.A., M.D.Oxon., M.R.C.P. (*Illustrated.*)

Dermatology. By James Galloway, M.D., F.R.C.P. (*Illustrated.*)

Tropical Diseases. By R. Tanner Hewlett, M.D., M.R.C.P., D.P.H.

REVIEWS OF BOOKS. (*Illustrated.*)

LITERARY GOSSIP.

PRACTICAL NOTES.

A MEDICAL CALENDAR.

Annual Subscription, 21s., post free.

CASSELL & Co., Ltd., London, Paris, New York & Melbourne.

THE MEDICAL GRADUATES' COLLEGE & POLYCLINIC

22, CHENIES STREET, LONDON, W.C.



Vice-Patrons:

THE LORD IVEAGH, K.P., LL.D.
THE RIGHT HON. LORD STRATHCONA AND MOUNT ROYAL, G.C.M.G.
THE RIGHT HON. A. J. BALFOUR, M.P., LL.D.
THE RIGHT HON. LORD AVEBURY, F.R.S.

President:

Sir Wm. H. Broadbent, Bart., LL.D., F.R.S.

Vice-Presidents:

Prof. Clifford Allbutt, LL.D., F.R.S.
Prof. McCall Anderson, M.D., F.F.P.S.
Sir John Banks, K.C.B., M.D.
Sir James Crichton Browne, LL.D., F.R.S., M.D.
Thomas Bryant, F.R.C.S.
Sir Joseph Fayrer, K.C.S.I., F.R.S., M.D.
Sir Wm. T. Gairdner, K.C.B., LL.D., M.D.
Jonathan Hutchinson, LL.D., F.R.S.

J. Hughlings Jackson, LL.D., F.R.S.
J. Fletcher Little, M.B., M.R.C.P.
Col. Kenneth McLeod, LL.D., M.D.
Prof. William Osler, LL.D., M.D.
Sir John Watt Reid, K.C.B., LL.D., M.D.
Sir John Burdon Sanderson, Bart., LL.D., F.R.S.
Sir John Batty Tuke, M.P., M.D.
Sir Samuel Wilks, Bart., LL.D., F.R.S.

Treasurer: Chas. Theodore Williams, M.D., F.R.C.P.

Dean: Guthrie Rankin, M.D., M.R.C.P.

Council:

Chairman: Jonathan Hutchinson, LL.D., F.R.S.

Vice-Chairman: Malcolm A. Morris, F.R.C.S.

James Berry, B.S., F.R.C.S.
Robt. Bowles, M.D., F.R.C.P.
James Cantlie, B.S., F.R.C.S.
Prof. Crookshank, M.B.
Alderman Crosby, M.D., F.R.C.S.
Alfred L. Galabin, M.D., F.R.C.P.
James F. Goodhart, M.D., F.R.C.P.

Alfred P. Hillier, M.D.
Constantine Holman, M.D.
Boyd Joll, M.B.
Sir William Kynsey, F.R.C.P.
Stephen Mackenzie, M.D., F.R.C.P.
Patrick Manson, F.R.S., LL.D., M.D.

George Oliver, M.D., F.R.C.P.
W. Miller Ord, M.D., F.R.C.P.
Solomon Smith, M.D., M.R.C.P.
James Taylor, M.D., F.R.C.P.
Seymour Taylor, M.D., F.R.C.P.
StClair Thomson, M.D., F.R.C.S.

Medical Superintendent:

A. E. Hayward Pinch, F.R.C.S.

The Electrical Standardizing, Testing and Training Institution.

Principal:

HUGH ERAT HARRISON, B.Sc., M.I.E.E.

Gentlemen's Sons Prepared for the ELECTRICAL ENGINEERING PROFESSION.

The training is thoroughly theoretical and practical, the Institution being associated with most of the leading Electrical Firms and Central Electric Lighting Stations, for the express purpose of affording its Students a proper practical insight into their future profession. Prospectus on application to the Secretary.

INSPECTING AND TESTING DEPARTMENT.

The Institution undertakes the inspection and test of electrical plant, and certifies the same either on behalf of Manufacturers or Buyers. Private testing rooms, supplied with current and apparatus, are let to Experimenters. Terms on application to the Secretary.

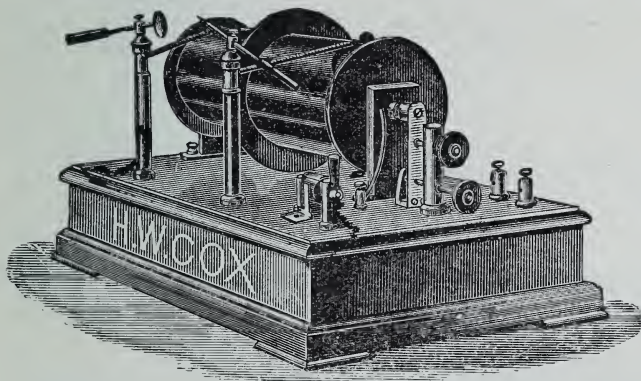
FARADAY HOUSE,
CHARING CROSS ROAD, LONDON, W.C.

Telegraphic Address:—"STANDARDIZING, LONDON."

X-RAYS APPARATUS

Of the Highest Quality and Finish only.

BUY DIRECT FROM THE MAKERS.



As supplied by us to H.M. Government for use in South Africa, The "Princess of Wales" Hospital Ship, Scottish National Red Cross Hospital, The Welsh Hospital, The Yeomanry Hospital, Medical Men, Hospitals, Chemists, and X-Ray Workers in all parts of the World. Our Apparatus gives the very best results, and we guarantee all our coils against breaking down.

Our price list, with simple instructions how to set about work, will be sent post free to readers of the "Polyclinic."

HARRY W. COX, Ltd.,

Manufacturing Electricians,

10, 11, and 28, CURSITOR STREET, CHANCERY LANE, W.C.

SPECIAL DARK ROOM FOR DEMONSTRATIONS.

PCL.—18 A

J. H. MONTAGUE,

SURGICAL INSTRUMENT MAKER AND CUTLER.

By Appointment to—
The Honourable Council of
India,
St. George's Hospital,
Westminster Hospital, &c.

TELEGRAPHIC ADDRESS—
"MASTOID, LONDON."

FLUX'S CHLOROFORM INHALER.

**For the safe
administration
of Chloroform.**

Vide the *Lancet*, Feb. 3rd, 1900.

Price, complete in Case,
£1 15 0



PATENT VACCINE EXPELLER.

Price 1/6 each,
or, 16/- per doz.

To meet the requirements
of the
Local Government Board.

Can be thoroughly
Sterilised.

PATENT ATMO-THERME STERILISER,

Made in Tin, 14 by 8 Price, £2 10 0

„ Copper, N.P., 14 by 8 „ £5 5 0

Any size made to order

CARTER BRAINE'S IMPROVED ORMSBY'S INHALER,

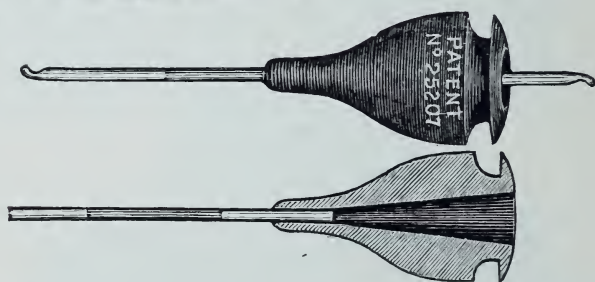
With Attachment for the Administration of A. C. E. Mixture and Chloroform.

Price Complete, Nickel Plated £3 3 0

COMPLETE OUTFITS for the PRODUCTION of RONTGEN'S "X" RAYS.

Skiaographs Taken at any Time, or by Appointment.

101, NEW BOND STREET, LONDON, W.



MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CONSULTATIONS AND LECTURES

From **SEPTEMBER** to **DECEMBER, 1900.**

Consultations at 4 p.m.

* Clinical Lectures at 5 p.m.

SPECIAL COURSES OF LECTURES AT 5.15 P.M.

| MONDAYS. (<i>Skin</i>) | TUESDAYS. (<i>Medical</i>) | WEDNESDAYS. (<i>Various</i>) | THURSDAYS. (<i>Surgical</i>) | FRIDAYS. (<i>Eye, Ear, Nose, and Throat.</i>) |
|--------------------------------------|---------------------------------------|--|-----------------------------------|--|
| September 3 College opens | September 4 Dr. W. Ewart | September 5 <i>Surgical Cons.</i> Mr. James Berry | September 6 Mr. Hutchinson | September 7 Mr. J. Griffith |
| September 10 Mr. Hutchinson | September 11 Dr. Seymour Taylor | *September 12 <i>Clinical Lecture.</i> Dr. Byrom Bramwell | September 13 Mr. Hutchinson | September 14 Dr. Dundas Grant |
| September 17 Dr. A. Whitfield | September 18 Dr. James Taylor | September 19 <i>Cons. Pædiatrics.</i> Dr. G. F. Still | September 20 Mr. Hutchinson | September 21 Mr. N. Macle hose |
| September 24 Mr. W. Anderson | September 25 Dr. C. Theo. Williams | *September 26 <i>Clinical Lecture.</i> Dr. A. E. Sansom | September 27 Mr. Hutchinson | September 28 Dr. St. Clair Thomson |
| October 1 Dr. T. Colcott Fox | October 2 Dr. J. E. Squire | October 3 <i>Medical Cons.</i> Dr. Alfred Hillier | October 4 Mr. Hutchinson | October 5 Mr. R. Lake |
| October 8 Dr. Jas. Galloway | October 9 Dr. James Taylor | *October 10 <i>Clinical Lecture.</i> Sir Wm. Gowers | October 11 Mr. Hutchinson | October 12 Mr. Treacher Collins |
| October 15 Mr. Malcolm Morris | October 16 Sir Wm. Broadbent | October 17 <i>Surgical Cons.</i> Mr. J. Cantlie | October 18 Mr. Hutchinson | October 19 Dr. St. Clair Thomson |
| October 22 Dr. T. Colcott Fox | October 23 Dr. Harry Campbell | *October 24th <i>Clinical Lecture.</i> Mr. W. H. A. Jacobson | October 25 Mr. Hutchinson | October 26 Dr. Dundas Grant |
| October 29 Dr. J. F. Payne | October 30 Sir Wm. Broadbent | October 31 <i>Surgical Cons.</i> Mr. Reg'd. Harrison | November 1 Mr. Hutchinson | November 2 Mr. Holmes Spicer |
| November 5 Dr. J. J. Pringle | November 6 Dr. R. L. Bowles | *November 7 <i>Clinical Lecture.</i> Dr. Chris. Childs | November 8 Mr. Hutchinson | November 9 Dr. Herbert Tilley |
| November 12 Mr. Malcolm Morris | November 13 Dr. W. Ewart | November 14 <i>Surgical Cons.</i> Mr. Johnson Smith | November 15 Mr. Hutchinson | November 16 Dr. Dundas Grant |
| November 19 Dr. J. F. Payne | November 20 Dr. S. J. Sharkey | *November 21 <i>Clinical Lecture.</i> Prof. Alfred Carter | November 22 Mr. Hutchinson | November 23 Mr. Holmes Spicer |
| November 26 Dr. Radcliffe Crocker | November 27 Dr. Seymour Taylor | November 28 <i>Cons. Pædiatrics.</i> Dr. W. B. Cheaile | November 29 Mr. Hutchinson | November 30 Dr. St. Clair Thomson |
| December 3 Mr. W. Anderson | December 4 Dr. Guthrie Rankin | *December 5 <i>Clinical Lecture</i> Sir Hector Cameron | December 6 Mr. Hutchinson | December 7 Mr. R. Lake |
| December 10 Mr. Malcolm Morris | December 11 Dr. Harry Campbell | December 12 <i>Surgical Cons.</i> Mr. E. W. Roughton | December 13 Mr. Hutchinson | December 14 Mr. Treacher Collins |
| December 17 Dr. Jas. Galloway | December 18 Dr. C. Theo. Williams | *December 19 <i>Clinical Lecture.</i> Dr. Burney Yeo | December 20 Mr. Hutchinson | December 21 Dr. Herbert Tilley |

October 12th, 19th, and 26th. Mr. HAYWARD PINCH—"The Clinical Examination of the Blood."

November 2nd, 9th, and 16th. Mr. P. J. FREYER—"Some Practical Points in the Surgery of the Urinary Organs."

December 3rd, 10th, and 17th. Dr. ST. CLAIR THOMSON—"The Surgical Anatomy of the Nose and Accessory Sinuses, including Nasal Suppuration."

GUTHRIE RANKIN, M.D., *Dean.*

A. E. HAYWARD PINCH, F.R.C.S., *Medical Superintendent.*

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

MICHAELMAS TERM, 1900.

PRACTICAL CLASSES.

| | | |
|--|---|---|
| Applied Anatomy (Medical and Surgical), Physical Diagnosis | { | Seymour Taylor, M.D., F.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S. |
| Clinical Examination of the Nervous System | { | James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P. |
| Practical Ophthalmology: the use of the Ophthalmoscope and Refraction | { | E. Treacher Collins, F.R.C.S. W. Holmes Spicer, M.B., F.R.C.S. John Griffith, F.R.C.S. |
| Practical Otology | { | J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S. |
| Practical Rhinology and Laryngology | { | StClair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P. |
| The Application of the Röntgen Rays | | F. Harrison Low, M.B. |
| Clinical Microscopy | | A. E. Hayward Pinch, F.R.C.S. |

COURSES OF LECTURES.

| | | |
|--|-----|------------------------------------|
| General Ophthalmology... .. | ... | R. Marcus Gunn, M.B., F.R.C.S. |
| Lectures and Demonstrations on Diseases of the Skin | ... | Phineas S. Abraham, M.D., F.R.C.S. |
| Administration of Anæsthetics... .. | ... | J. F. W. Silk, M.D. |
| Diseases of Children | ... | G. F. Still, M.D., M.R.C.P. |

CLASSES IN ASSOCIATION WITH THE COLLEGE.

| | | |
|----------------------------------|-----|-----------------------------------|
| Practical Bacteriology | ... | Professor Crookshank, M.B. |
| Mental Diseases | ... | Maurice Craig, M.D., M.R.C.P. |
| Hygiene and Public Health | ... | A. Wynter Blyth, M.R.C.S., F.C.S. |

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, W.C.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC,
22, *Chenies Street, Gower Street, London, W.C.*

CONSULTATIONS ARE HELD AT 4 P.M. AS FOLLOWS:

Mondays (Skin); Tuesdays (Medical); Wednesdays (Various);
Thursdays (Surgical); Fridays (Eye, Ear, Throat, and Nose).

Clinical Lectures are given on alternate Wednesdays.

Short courses of didactic lectures on special subjects are delivered every month.

The Laboratory is open for private research to Members upon terms which can be ascertained on inquiry.

Analyses are undertaken and reports furnished upon pathological specimens submitted for examination.

The Christmas Term of practical classes will commence on Monday, Nov. 5.

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis.
Tuesdays and Thursdays, at 6 P.M., commencing Nov. 5.
Dr. Seymour Taylor and Mr. James Cantlie.

Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M.,
commencing Nov. 9. Dr. James Taylor.

Practical Application of Röntgen Rays. Thursdays, 3 P.M., com-
mencing Nov. 8. Dr. Harrison Low.

Practical Ophthalmology: the Use of the Ophthalmoscope and
Refraction. Fridays, 5 to 7 P.M., commencing Nov. 9. Mr. J.
Griffith.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M.,
commencing Nov. 7. Dr. Herbert Tilley.

Practical Otology. Mondays, 5 to 7 P.M., commencing Nov. 5.
Dr. Dundas Grant.

Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30 P.M., com-
mencing Nov. 5. Mr. Hayward Pinch.

Morbid Conditions of the Urine and their Clinical Significance.
Tuesdays and Thursdays, 2 to 3.30 P.M.

Fee for each class, £2 2s. Composition fee for any three classes,
£5 5s.

EXTRA-MURAL CLASSES.

(*In association with the College.*)

Practical Bacteriology. Daily, 10 A.M. to 4 P.M. Fee, £5 5s. for
one month; £8 8s. for two months. Professor Crookshank.

Advanced Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee,
£2 2s. Dr. Nash.

Hygiene and Public Health. Fee, £2 2s. Dr. Wynter Blyth.

Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.

Extra classes in any subject will be formed to suit the con-
venience of practitioners unable to attend those already provided.

A detailed syllabus of any of the above classes may be obtained
on application to the Medical Superintendent, 22, *Chenies Street*,
Gower Street, W.C.

PLASMON

USES IN DISEASE.

This Natural Milk Proteid, Highly Nutritious, Easily Digested, and Readily Assimilated Food, is intended for Infants and Adults whose digestive functions are impaired by illness or senile decay. Rich in Albumins and Phosphates of Lime, Iron, Sodium and Potassium, it forms an ideal food for the repair of Tissues—whether, Muscle, Nerve or Bone.

In the Dietary of Typhoid and other Fever Patients, Plasmon takes a very high place and is preferred to milk by many. It does not form a heavy clot like milk, and the green appearance of the stools soon disappears.

It does not in any way increase the temperature; by maintaining the **Nitrogen equilibrium** it has the reverse effect.

In the **Treatment of Consumption,** Plasmon will be found to be an ideal food by reason of its highly nitrogenous value and its digestible nature. It does not nauseate the patient, as 3 or 4 lbs. of beef steak, or 6 to 8 pints of milk per day would—**one tea-spoonful** of Plasmon being equivalent to 4 ounces of beef steak, or 1½ pints of milk, in nutrient value.

In Strumous, Marasmic, and other Tubercular affections, Plasmon forms a food that produces most favourable results. Very marked effects are obtained in **Rickets,** and other Bone disorders, the Salts of Milk supplying all that is necessary for the development of healthy bone tissue.

In cases of **Peritonitis** and such like abdominal affections, Plasmon will be found very useful, as it is almost entirely absorbed, and causes no irritation along the alimentary tract. In cases of abdominal surgery where absolute rest is required for the bowels Plasmon forms an ideal diet.

In **Neurasthenia** and cases of **Multiple Neuritis,** Plasmon, as a Food and Therapeutic Agent, is held in very high esteem. Plasmon has very powerful action on the Nerve Tissues, supplying the Phosphorus necessary for the building up of healthy nerve cells. It is perfectly soluble, forming a neutral solution.

*SAMPLES, together with MEDICAL EVIDENCE & MEDICAL PRESS REPORTS,
Free of Charge, sent to Medical Men and Nurses only.*

PRICES: Plasmon Granulated Powder—

| | | | | | | |
|------------|----|----|----|----|----|-----------------|
| Small size | .. | .. | .. | .. | .. | 9d. per packet. |
| Medium „ | .. | .. | .. | .. | .. | 1s. 4d. „ |
| Large „ | .. | .. | .. | .. | .. | 2s. 6d. „ |

The Plasmon Syndicate, Ltd.,
56, Duke Street, Grosvenor Square, LONDON, W.

Concise yet comprehensive summaries of all in periodical literature important to the practitioner. Facts, not mere opinions, characterise the "Review," instead of the commonplace remarks and indiscriminate and useless notices of crude and unproved views which constitute many so called "Epitomes."

The Medical Review

(MEDICAL AND SURGICAL REVIEW OF REVIEWS.)

AN INDEXED AND ILLUSTRATED
MONTHLY RECORD OF ALL THAT IS IMPORTANT TO THE PRACTITIONER IN THE
MEDICAL PERIODICALS IN THE WORLD.

PRINTED IN LARGE CLEAR TYPE, ON SUPERFINE PAPER.

Subscription £1 per annum, post free to any part of the world.

By the suppression of all unessential matter, a paper written with any definite object—and such alone is valuable—can generally be compressed into a comparatively brief report, and yet remain a clear and readable account of the subject, so that nothing of importance is lost, and often, in lucidity, much is gained. Merely to mention a few of the leading features of an article serves no useful purpose.

" . . . A great boon to the profession all over the world. . . . I applaud not only your scheme, but the manner of its execution. . . ."—JONATHAN HUTCHINSON, LL.D., F.R.S., Ex-President of the Royal College of Surgeons, England.

"Extremely useful to the busy practitioner."—*Lancet*.

" . . . I think you are about to fill a very great want. . . ."—T. CLIFFORD ALLBUTT, M.A., M.D., F.R.C.P., F.R.S., Regius Prof. of Physic, Cambridge University.

" . . . It would be impossible for such a journal not to take at once a first place. . . ."—*Birmingham Medical Review*.

" . . . Of great value to the general practitioner, and to teachers and authors. . . ."—BYROM BRAMWELL, M.D., F.R.C.P. Edin.

"Destined to the greatest and legitimate success. . . . Well edited. Giving an exact account of all of importance in science and medical practice."—*Journal des Practiciens*.

"The 'Review' brings me into touch with methods and ideas which I could not possibly have otherwise obtained. . . . No surgeon can afford to do without such an excellent index to scientific progress."—J. O'CONOR, M.A., M.D., Senior Medical Officer, British Hospital, Buenos Ayres.

IMPORTANT TO NEW SUBSCRIBERS.

BACK NUMBERS.

The attention of new subscribers is called to the desirability of applying for Vols. I. and II. of the "REVIEW" before they are out of print.

As the important facts recorded in the "REVIEW" are not presented as isolated contributions only, but as collated records, the bound volumes present, in a unique manner, the definite progress of medical science, and render all that is important to the practitioner in the current medical periodicals readily accessible.

Already one of the parts has had to be reprinted, and now only a limited number of Vol. II. is available for new subscribers. The first 500 new subscribers to the "REVIEW" for this current year, who purchase Vol. II. will each be entitled to a bound copy of Vol. I. (Nos. 1, 2 and 3) free of charge.

The price for Vol. II., crown 4to, cloth, is 21/- net.

All communications to be addressed to the SECRETARY, Cheques and Postal Orders should be made payable to THE MEDICAL AND SURGICAL "REVIEW OF REVIEWS," LIMITED, 12, Norfolk Street, Strand, London, W.C., and crossed "BROWN, JANSON & Co."

NEW SYDENHAM SOCIETY.

SALE OF SURPLUS VOLUMES.

IN order to reduce its Stock-in-hand, the Society is now offering many of the past Volumes at almost nominal cost. Among them are those of Graves, Niemeyer, Stokes, Trousseau (Vols. i., iv., v.), Charcot, Marie, Spiegelberg, Pozzi, and many others. The Volumes have been re-arranged in Guinea Sets. In some instances as many as Eight Volumes may be obtained for One Guinea. Full Catalogues may be obtained from

MR. H. K. LEWIS, 136, Gower Street, W.C.

The following are the Contents of some of the Sets :—

SET I.—Three Vols.

Two Monographs on Malaria and the Parasites of Malarial Fevers
Laveran on Paludism.

Selected Monographs, Vol. 121, on Malaria, &c.

SET III.—Five Vols.

Binz's Lectures on Pharmacology, 2 Vols.

Naunyn on Cholelithiasis.

Ewald's Disorders of Digestive Organs, 2 Vols.

SET V.—Eight Vols.

The Works of Sir William Gull, 2 Vols.

The Collected Works of Dr. Addison.

Latham's Works, 2 Vols.

Selections from the Works of Colles.

Warburton Begbie's Works.

Graves's Clinical Medicine, 2 Vols.

SET VII.—Six Vols.

Selected Monographs on Dermatology (Unna, Nielsen, Duhring, Bronson,
Blanc, Berger, Prince-Morrow).

Essays on Acromegaly (Pierre Marie and Souza Leite).*

The Works of Sir William Gull, 2 Vols.

Monographs and Lectures from German Sources, Series iii.

Selected Monographs, Vol. 110.

SET VIII.—Seven Vols.

Billroth's Clinical Surgery (Illustrated).

Essays on Micro-Parasites in Disease. Selected by Watson Cheyne
(Illustrated).

Monographs and Lectures from German Sources, Series iii., Vol. 148.

Essays on Acromegaly (Pierre Marie and Souza Leite).

Memoirs on Diphtheria.

Lancereaux's Syphilis, 2 Vols.

SET X.—Eight Vols.

Selected Lectures and Papers from Foreign Sources, Vol. 161.

Naunyn on Cholelithiasis.

Hebra's Diseases of the Skin, Vols. ii., iii., iv. and v.

Griesinger on Mental Pathology.

Niemeyer's Lectures on Pulmonary Consumption.

SET XI.—Seven Vols.

Naunyn on Cholelithiasis.

Stricker's Histology, Human and Comparative, 3 Vols. (Illustrated).

Selections from the Works of Dr. Duchenne.

Koch's Researches on Wound Infection.

Stokes on Diseases of the Chest.

THERE ARE XXIV. SUCH SETS.

Medium 8vo. Cloth lettered. 15s. net. Post Free 16s.

A HANDBOOK OF THE GNATS OR MOSQUITOES.

MAINLY intended for the Use of Students of Tropical Medicine giving the Anatomy and Life History of the Culicidæ, with Tables and a Compilation of the descriptions of over 240 species, and Illustrated with one folding and seven full-page plates, and numerous figures in the text.

By MAJOR GEO. M. GILES, I.M.S., M.B.Lond., F.R.C.S.,

Formerly Naturalist to the Indian Marine Survey.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Gt. Titchfield Street, W.

Demy 8vo. Fully Illustrated. Price 1s. 6d. net; Post Free 1s. 8d.

BRITISH SANATORIA

FOR THE
OPEN-AIR TREATMENT OF TUBERCULOSIS.

[Reprinted with additions and alterations from the "West London Medical Journal."]

N.B.—This book will be found invaluable to Medical Men as well as the general public seeking information on the above subject.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Great Titchfield Street, London, W.

PERSONS desiring to communicate with THE LONDON SCHOOL OF TROPICAL MEDICINE should address The Medical Tutor, London School of Tropical Medicine, Seamen's Hospital, Royal Albert Dock, E., or The Secretary, P. Michelli, Esq., Seamen's Hospital, Greenwich, S.E.

THE JOURNAL OF TROPICAL MEDICINE.

A MONTHLY JOURNAL DEVOTED TO MEDICAL, SURGICAL AND GYNÆCOLOGICAL WORK IN THE TROPICS.

Edited by James Cantile, M.B., F.R.C.S., and W. J. Simpson, M.D., F.R.C.P.

Published by JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield St., London, W.

Subscription, 17/- per annum, payable in advance.

With Illustrations, 808 pages, crown 8vo, 12s. 6d.

AN INDEX OF MEDICINE:

A Manual for the Use of Senior Students and Others,

BY

SEYMOUR TAYLOR, M.D., F.R.C.P.,

Physician to the West London Hospital.

PRESS OPINIONS.

The Lancet.—"Dr. Seymour Taylor may certainly be congratulated on the success of his labours. He has produced exactly what he desired, and the book may confidently be recommended to those for whom it is intended."

The British Medical Journal.—"As a supplement to the larger standard treatises, and so as a means of codifying the knowledge of the more advanced, it will prove invaluable."

London: SMITH, ELDER & CO.

THE STUDENT'S Laryngology Set of Instruments.

Specially designed to meet the requirements of the Classes held
at the Polyclinic and Medical Graduates' College, London.

THIS Set consists of the following Instruments of best quality, and is supplied either in plain cardboard box or in leather-covered cases as under :—

- Head Mirror, with either band or spectacle frames.
- 3 Laryngeal Mirrors of different sizes, fitting into one metal handle.
- 1 Post Nasal Mirror, in metal handle.
- 2 Laryngeal Mirrors, marked "L," in ivory handle. } For Syphilitic Cases
- 1 Tongue Depressor, marked "L." } (Lues).
- 1 do. do.
- 1 Nasal Speculum.
- 1 Set of 3 Aural Specula.
- 1 Flexible Probe.
- 1 Pair of Dressing Forceps.

Price, Complete in Cardboard Box, £2 10s. net, or in leather-covered Case with Catch, 9s. extra.

Forceps for Peritonsillar Abscess

(Suggested by Dr. StClair Thomson).



THESE Forceps are a slight modification of Lord Lister's Sinus Forceps. Being intended chiefly for use in the Throat and Nose, they have been made with a crank handle, so that the field of operation is not concealed by the surgeon's hand. They will be found particularly useful for opening peritonsillar abscesses. When the abscess is pointing, generally at the upper end of the tonsil, firm pressure with the extremity of the Forceps will readily detect the site of suppuration and with slight increase in force the point can be made to penetrate the abscess easily. In withdrawing them the two blades should be separated as in Hilton's method.

The Forceps are also very useful in removing foreign bodies from the nose.

Price, Nickel-plated, 5s. 6d. each, or with Aseptic Joint, 6s. 6d.

ALLEN & HANBURY, Ltd.,

Surgical Instrument Manufacturers,

Surgical Instrument Department: 48, WIGMORE STREET, W.

CITY HOUSE:

INSTRUMENT FACTORY:

PLOUGH COURT, LOMBARD STREET, E.C. 59, WEYMOUTH STREET, W.

LONDON.

JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield Street, Oxford Street, W.

The Polyclinic

BEING THE JOURNAL OF THE

Medical Graduates' College London.

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION
OF THE MUSEUM AND LIBRARY COMMITTEE, BY

JONATHAN HUTCHINSON.

COMMITTEE OF CO-OPERATION.

T. CLIFFORD ALLBUTT.
ALFRED GALABIN.
STEPHEN MACKENZIE.
WM. MILLER ORD.

SIR WM. BROADBENT.
J. HUGHLINGS JACKSON.
MALCOLM MORRIS.
C. THEODORE WILLIAMS.

CONTENTS.

| | PAGE |
|---|--------|
| OUR NEXT DINNER | 311 |
| APPENDICITIS | 313 |
| PAGET'S CANCER OF THE NIPPLE REGION | 315 |
| TIERRA DEL FUEGO | 316 |
| CHANGE OF FAST-DAY DIET AT THE TIME OF THE REFORMATION | 318 |
| THE NATURE OF ALOPECIA AREATA | 319 |
| SELECTIONS FROM CLINICAL LECTURES: | |
| SOME REMARKS ON THE QUESTION OF EARLY OPERATION IN ACUTE . | |
| APPENDICITIS: | |
| W. H. A. JACOBSON, M.Ch.Oxon. | 320 |
| ABSTRACT OF LECTURE ON THE BACTERIAL PURIFICATION OF SEWAGE | |
| (ESPECIALLY IN RELATION TO THE PREVENTION OF TYPHOID FEVER | |
| AND OTHER WATER-BORNE DISEASES: | |
| CHRISTOPHER CHILDS, M.A., M.D.Oxon., D.Ph.... .. | 339 |
| LECTURES ON RESUSCITATION FROM DROWNING, &c.: | |
| DR. BOWLES | 340 |
| NOTES OF CASES DEMONSTRATED IN CONSULTATIONS: | |
| MEDICAL CASES: DR. BOWLES | 345 |
| SURGICAL CASES: W. JOHNSON SMITH, F.R.C.S. | 347 |
| LARYNGOLOGY AND OTOTOLOGY: HERBERT TILLEY, M.D., F.R.C.S. | 350 |
| DERMATOLOGY: MR. MALCOLM MORRIS | 352 |
| CASES WITH COMMENTS FROM THE SURGICAL CLINIC: MR. HUTCHINSON | 352 |
| COLLEGE NOTES, BY THE DEAN | 358 |
| CATALOGUE-COMPANION TO THE MUSEUM | 363 |
| CORRESPONDENCE AND ANSWERS | 371 |
| TITLE PAGE AND INDEX TO VOL. III. | at end |

Published by

JOHN BALE, SONS & DANIELSSON, LTD.

OXFORD HOUSE,

83-89, GREAT TITCHFIELD STREET, OXFORD STREET, LONDON, W.

Price : One Shilling.



TRADE MARK 'Soloid' BRAND PRODUCTS

Provide the best means of carrying the materials for promptly preparing reliable solutions of any desired strength. They are compact and convenient, accurate, safe to carry, and promptly soluble. The number of preparations issued under the 'Soloid' brand is being continually increased, the more recent additions including 'Soloid' Carbolic Acid, gr. 5, 'Soloid' Potassium Permanganate and Alum, 'Soloid' Microscopic Stains, and 'Soloid' Indicators (see Wellcome's Medical Diary).



BURROUGHS WELLCOME & CO.,
LONDON AND SYDNEY.

THE PRACTITIONER.

A JOURNAL OF PRACTICAL MEDICINE.

EDITED BY

MALCOLM MORRIS.

The DECEMBER PART, Price 2/-, contains:—

THE MONTH:—

The College of Surgeons and its Members.

An Opportunity for a Gracious Act.

The Shadow of Coming Events.

A Proposed Federation of Paris Medical Societies.

A London Academy of Medicine.

An Example of Combination.

The Endowment of Medicine.

London as a Medical Centre.

An American View of Continental Doctors.

Medical Men in Politics.

A Febrifuge for Khaki Fever.

ORIGINAL COMMUNICATIONS:—

ORAL SEPSIS AS A CAUSE OF "SEPTIC GASTRITIS," "TOXIC NEURITIS," AND OTHER SEPTIC CONDITIONS. By William Hunter, M.D., F.R.C.P.

A CLINICAL LECTURE ON SUPRAPUBIC CYSTOTOMY. By Alfred Willett, F.R.C.S.

A CLINICAL DEMONSTRATION ON THE ANATOMY OF THE SPINAL CORD. By H. H. Tooth, M.D., F.R.C.P.

A MEDICO-LITERARY CAUSERIE:—

Poisoners, Old and New.—III.

PUBLIC HEALTH:—

Hospital Hygiene: A Study of the Methods of Preventing the Spread of Infectious Diseases in Children's Hospitals. (*Illustrated.*)

A REVIEW OF THE MEDICAL SCIENCES:—

Recent Work on the Nature of Hæmolysis and its Relation to Practical Bacterial Therapeutics. By William Bulloch, M.D.

Midwifery. By W. E. Fothergill, M.A., B.Sc., M.D. (*Illustrated.*)

Dental Surgery. By Arthur S. Underwood, M.R.C.S., L.D.S.

REVIEWS OF BOOKS. (*Illustrated.*)

NOVELTIES AND NEW PREPARATIONS.

PRACTICAL NOTES.

A MEDICAL CALENDAR.

GENERAL INDEX.

Annual Subscription, 21s., post free.

CASSELL & Co., Ltd., London, Paris, New York & Melbourne.

THE MEDICAL GRADUATES' COLLEGE & POLYCLINIC

22, CHENIES STREET, LONDON, W.C.



Vice-Patrons:

THE LORD IVEACH, K.P., LL.D.
THE RIGHT HON. LORD STRATHCONA AND MOUNT ROYAL, G.C.M.G.
THE RIGHT HON. A. J. BALFOUR, M.P., LL.D.
THE RIGHT HON. LORD AVEBURY, F.R.S.

President:

Sir Wm H. Broadbent, Bart., LL.D., F.R.S

Vice-Presidents:

Prof. Clifford Allbutt, LL.D., F.R.S.
Prof. McCall Anderson, M.D., F.F.P.S.
Sir John Banks, K.C.B., M.D.
Sir James Crichton Browne, LL.D., F.R.S., M.D.
Thomas Bryant, F.R.C.S.
Sir Joseph Fayrer, K.C.S.I., F.R.S., M.D.
Sir Wm. T. Gairdner, K.C.B., LL.D., M.D.
Jonathan Hutchinson, LL.D., F.R.S.

J. Hughlings Jackson, LL.D., F.R.S.
J. Fletcher Little, M.B., M.R.C.P.
Col. Kenneth McLeod, LL.D., M.D.
Prof. William Osler, LL.D., M.D.
Sir John Watt Reid, K.C.B., LL.D., M.D.
Sir John Burdon Sanderson, Bart., LL.D., F.R.S.
Sir John Batty Tuke, M.P., M.D.
Sir Samuel Wilks, Bart., LL.D., F.R.S.

Treasurer: Chas. Theodore Williams, M.D., F.R.C.P

Dean: Guthrie Rankin, M.D., M.R.C.P.

Council:

Chairman: Jonathan Hutchinson, LL.D., F.R.S

Vice-Chairman: Malcolm A. Morris, F.R.C.S.

James Berry, B.S., F.R.C.S.
Robt. Bowles, M.D., F.R.C.P.
James Cantlie, B.S., F.R.C.S.
Prof. Crookshank, M.B.
Alderman Crosby, M.D., F.R.C.S.
Alfred L. Galabin, M.D., F.R.C.P.
James F. Goodhart, M.D., F.R.C.P.

Alfred P. Hillier, M.D.
Constantine Holman, M.D.
Boyd Joll, M.B.
Sir William Kynsey, F.R.C.P.
Stephen Mackenzie, M.D., F.R.C.P.
Patrick Manson, F.R.S., LL.D., M.D.

George Oliver, M.D., F.R.C.P.
W. Miller Ord, M.D., F.R.C.P.
Solomon Smith, M.D., M.R.C.P.
James Taylor, M.D., F.R.C.P.
Seymour Taylor, M.D., F.R.C.P.
StClair Thomson, M.D., F.R.C.S.

Medical Superintendent:

A. E. Hayward Pinch, F.R.C.S.

The Electrical Standardizing, Testing and Training Institution.

Principal:

HUGH ERAT HARRISON, B.Sc., M.I.E.E.

Gentlemen's Sons Prepared for the ELECTRICAL ENGINEERING PROFESSION.

The training is thoroughly theoretical and practical, the Institution being associated with most of the leading Electrical Firms and Central Electric Lighting Stations, for the express purpose of affording its Students a proper practical insight into their future profession. Prospectus on application to the Secretary.

INSPECTING AND TESTING DEPARTMENT.

The Institution undertakes the inspection and test of electrical plant, and certifies the same either on behalf of Manufacturers or Buyers. Private testing rooms, supplied with current and apparatus, are let to Experimenters. Terms on application to the Secretary.

FARADAY HOUSE,

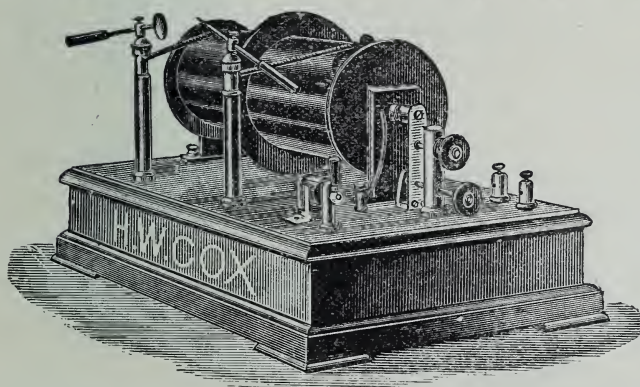
CHARING CROSS ROAD, LONDON, W.C.

Telegraphic Address:—"STANDARDIZING, LONDON."

X-RAYS APPARATUS

Of the Highest Quality and Finish only.

BUY DIRECT FROM THE MAKERS.



As supplied by us to H.M. Government for use in South Africa, The "Princess of Wales" Hospital Ship, Scottish National Red Cross Hospital, The Welsh Hospital, The Yeomanry Hospital, Medical Men, Hospitals, Chemists, and X-Ray Workers in all parts of the World. Our Apparatus gives the very best results, and we guarantee all our coils against breaking down.

Our price list, [with simple instructions how to set about work, will be sent post free to readers of the "Polyclinic."

HARRY W. COX, Ltd.,

Manufacturing Electricians,

10, 11, and 28, CURSITOR STREET, CHANCERY LANE, W.C.

SPECIAL DARK ROOM FOR DEMONSTRATIONS.

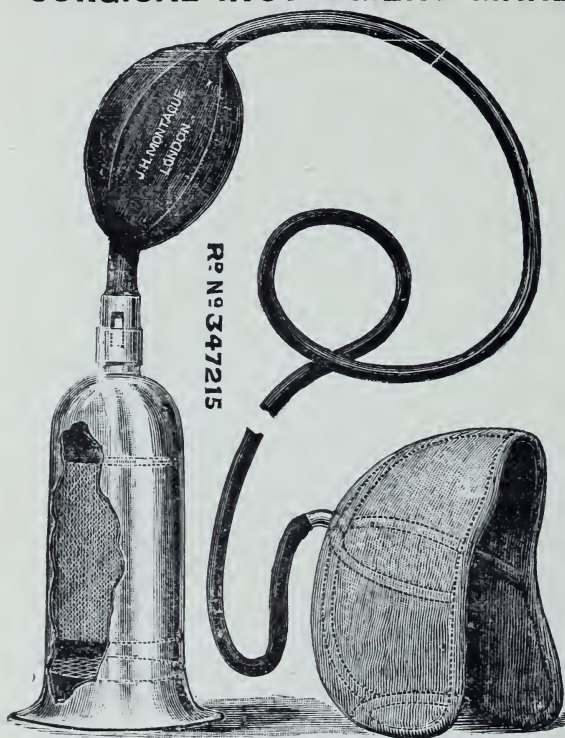
PCL.—22 A

J. H. MONTAGUE,

SURGICAL INSTRUMENT MAKER AND CUTLER.

By Appointment to—
The Honourable Council of
India,
St. George's Hospital,
Westminster Hospital, &c.

TELEGRAPHIC ADDRESS—
"MASTOID, LONDON."



PATENT VACCINE EXPELLER.

Price 1/6 each,
or, 16/- per doz.

To meet the requirements
of the
Local Government Board.

Can be thoroughly
Sterilised.

PATENT ATMO-THERME STERILISER,

Made in Tin, 14 by 8 Price, £2 10 0

" Copper, N.P., 14 by 8 " £5 5 0

Any size made to order

CARTER BRAINE'S IMPROVED ORMSBY'S INHALER,

With Attachment for the Administration of A. C. E. Mixture and Chloroform.

Price Complete, Nickel Plated £3 3 0

COMPLETE OUTFITS for the PRODUCTION of RONTGEN'S "X" RAYS.

Skiagraphs Taken at any Time, or by Appointment.

101, NEW BOND STREET, LONDON, W.

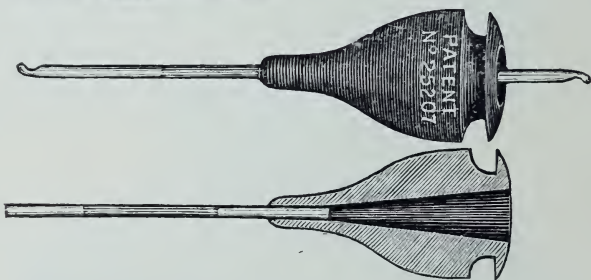
FLUX'S CHLOROFORM INHALER.

For the safe
administration
of Chloroform.

Vide the *Lancet*, Feb. 3rd, 1900.

Price, complete in Case,

£1 15 0



MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

SCHEDULE OF CONSULTATIONS AND LECTURES

From **SEPTEMBER** to **DECEMBER**, 1900.

Consultations at 4 p.m.

* Clinical Lectures at 5 p.m.

SPECIAL COURSES OF LECTURES AT 5.15 P.M.

| MONDAYS. (Skin) | TUESDAYS. (Medical) | WEDNESDAYS. (Various) | THURSDAYS. (Surgical) | FRIDAYS. (Eye, Ear, Nose, and Throat.) |
|--------------------------------------|---------------------------------------|--|--------------------------------|--|
| September 3 College opens | September 4 Dr. W. Ewart | September 5 <i>Surgical Cons.</i> Mr. James Berry | September 6 Mr. Hutchinson | September 7 Mr. J. Griffith |
| September 10 Mr. Hutchinson | September 11 Dr. Seymour Taylor | *September 12 <i>Clinical Lecture.</i> Dr. Byron Bramwell | September 13 Mr. Hutchinson | September 14 Dr. Dundas Grant |
| September 17 Dr. A. Whitfield | September 18 Dr. James Taylor | September 19 <i>Cons. Pædiatrics.</i> Dr. G. F. Still | September 20 Mr. Hutchinson | September 21 Mr. N. Maclehorse |
| September 24 Mr. W. Anderson | September 25 Dr. C. Theo. Williams | *September 26 <i>Clinical Lecture.</i> Dr. A. E. Sansom | September 27 Mr. Hutchinson | September 28 Dr. St. Clair Thomson |
| October 1 Dr. T. Colcott Fox | October 2 Dr. J. E. Squire | October 3 <i>Medical Cons.</i> Dr. Alfred Hillier | October 4 Mr. Hutchinson | October 5 Mr. R. Lake |
| October 8 Dr. Jas. Galloway | October 9 Dr. James Taylor | *October 10 <i>Clinical Lecture.</i> Sir Wm. Gowers | October 11 Mr. Hutchinson | October 12 Mr. Treacher Collins |
| October 15 Mr. Malcolm Morris | October 16 Sir Wm. Broadbent | October 17 <i>Surgical Cons.</i> Mr. J. Cantlie | October 18 Mr. Hutchinson | October 19 Dr. St. Clair Thomson |
| October 22 Dr. T. Colcott Fox | October 23 Dr. Harry Campbell | *October 24th <i>Clinical Lecture.</i> Mr. W. H. A. Jacobson | October 25 Mr. Hutchinson | October 26 Dr. Dundas Grant |
| October 29 Dr. J. F. Payne | October 30 Sir Wm. Broadbent | October 31 <i>Surgical Cons.</i> Mr. Reg'd. Harrison | November 1 Mr. Hutchinson | November 2 Mr. Holmes Spicer |
| November 5 Dr. J. J. Pringle | November 6 Dr. R. L. Bowles | *November 7 <i>Clinical Lecture.</i> Dr. Chris. Childs | November 8 Mr. Hutchinson | November 9 Dr. Herbert Tilley |
| November 12 Mr. Malcolm Morris | November 13 Dr. W. Ewart | November 14 <i>Surgical Cons.</i> Mr. Johnson Smith | November 15 Mr. Hutchinson | November 16 Dr. Dundas Grant |
| November 19 Dr. J. F. Payne | November 20 Dr. S. J. Sharkey | *November 21 <i>Clinical Lecture.</i> Prof. Alfred Carter | November 22 Mr. Hutchinson | November 23 Mr. Holmes Spicer |
| November 26 Dr. Radcliffe Crocker | November 27 Dr. Seymour Taylor | November 28 <i>Cons. Pædiatrics.</i> Dr. W. B. Cheandle | November 29 Mr. Hutchinson | November 30 Dr. St. Clair Thomson |
| December 3 Mr. W. Anderson | December 4 Dr. Guthrie Rankin | *December 5 <i>Clinical Lecture</i> Sir Hector Cameron | December 6 Mr. Hutchinson | December 7 Mr. R. Lake |
| December 10 Mr. Malcolm Morris | December 11 Dr. Harry Campbell | December 12 <i>Surgical Cons.</i> Mr. E. W. Roughton | December 13 Mr. Hutchinson | December 14 Mr. Treacher Collins |
| December 17 Dr. Jas. Galloway | December 18 Dr. C. Theo. Williams | *December 19 <i>Clinical Lecture.</i> Dr. Burney Yeo | December 20 Mr. Hutchinson | December 21 Dr. Herbert Tilley |

October 12th, 19th, and 26th. Mr. HAYWARD PINCH—"The Clinical Examination of the Blood."

November 2nd, 9th, and 16th. Mr. P. J. FREYER—"Some Practical Points in the Surgery of the Urinary Organs."

December 3rd, 10th, and 17th. Dr. ST. CLAIR THOMSON—"The Surgical Anatomy of the Nose and Accessory Sinuses, including Nasal Suppuration."

GUTHRIE RANKIN, M.D., *Dean.*

A. E. HAYWARD PINCH, F.R.C.S., *Medical Superintendent.*

President of the College.

SIR WM. H. BROADBENT, BART., F.R.S., LL.D.

TEACHING STAFF.

CHRISTMAS TERM, 1900.

PRACTICAL CLASSES.

| | | |
|--|---|---|
| Applied Anatomy (Medical and Surgical), Physical Diagnosis | { | Seymour Taylor, M.D., F.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S. |
| Clinical Examination of the Nervous System | { | James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P. |
| Practical Ophthalmology: the use of the Ophthalmoscope and Refraction | { | E. Treacher Collins, F.R.C.S. W. Holmes Spicer, M.B., F.R.C.S. John Griffith, F.R.C.S. |
| Practical Otology | { | J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S. |
| Practical Rhinology and Laryngology | { | StClair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P. |
| The Application of the Röntgen Rays | | F. Harrison Low, M.B. |
| Clinical Microscopy | | A. E. Hayward Pinch, F.R.C.S. |

COURSES OF LECTURES.

| | | |
|--|-----|------------------------------------|
| General Ophthalmology... .. | ... | R. Marcus Gunn, M.B., F.R.C.S. |
| Lectures and Demonstrations on Diseases of the Skin | ... | Phineas S. Abraham, M.D., F.R.C.S. |
| Administration of Anæsthetics... .. | ... | J. F. W. Silk, M.D. |
| Diseases of Children | ... | G. F. Still, M.D., M.R.C.P. |

CLASSES IN ASSOCIATION WITH THE COLLEGE.

| | | |
|----------------------------------|-----|-----------------------------------|
| Practical Bacteriology | ... | Professor Crookshank, M.B. |
| Mental Diseases | ... | Maurice Craig, M.D., M.R.C.P. |
| Hygiene and Public Health | ... | A. Wynter Blyth, M.R.C.S., F.C.S. |

A detailed syllabus of any of the above classes may be obtained on application to the Medical Superintendent, 22, Chenies Street, W.C.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC,
22, *Chenies Street, Gower Street, London, W.C.*

CONSULTATIONS ARE HELD AT 4 P.M. AS FOLLOWS :

Mondays (Skin); Tuesdays (Medical); Wednesdays (Various);
Thursdays (Surgical); Fridays (Eye, Ear, Throat, and Nose).

Clinical Lectures are given on alternate Wednesdays.

Short courses of didactic lectures on special subjects are delivered every month.

The Laboratory is open for private research to Members upon terms which can be ascertained on inquiry.

Analyses are undertaken and reports furnished upon pathological specimens submitted for examination.

The Christmas Term of practical classes commenced on Monday, Nov. 5.

PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis.
Tuesdays and Thursdays, at 6 P.M., commenced Nov. 5.
Dr. Seymour Taylor and Mr. James Cantlie.

Clinical Examination of the Nervous System. Fridays, 2 to 3.30 P.M.,
commenced Nov. 9. Dr. James Taylor.

Practical Application of Röntgen Rays. Thursdays, 3 P.M., com-
menced Nov. 8. Dr. Harrison Low.

Practical Ophthalmology: the Use of the Ophthalmoscope and
Refraction. Fridays, 5 to 7 P.M., commenced Nov. 9. Mr. J.
Griffith.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M.,
commenced Nov. 7. Dr. Herbert Tilley.

Practical Otology. Mondays, 5 to 7 P.M., commenced Nov. 5.
Dr. Dundas Grant.

Clinical Microscopy. Mondays and Wednesdays, 2 to 3.30. P.M., com-
menced Nov. 5. Mr. Hayward Pinch.

Morbid Conditions of the Urine and their Clinical Significance.
Tuesdays and Thursdays, 2 to 3.30 P.M.

Fee for each class, £2 2s. Composition fee for any three classes,
£5 5s.

EXTRA-MURAL CLASSES.

(*In association with the College.*)

Practical Bacteriology. Daily, 10 A.M. to 4 P.M. Fee, £5 5s. for
one month; £8 8s. for two months. Professor Crookshank.

Advanced Clinical Bacteriology. Wednesdays, 2 to 3.30 P.M. Fee,
£2 2s. Dr. Nash.

Hygiene and Public Health. Fee, £2 2s. Dr. Wynter Blyth.

Mental Diseases. Fee, £1 1s. Dr. Maurice Craig.

Extra classes in any subject will be formed to suit the con-
venience of practitioners unable to attend those already provided.

A detailed syllabus of any of the above classes may be obtained
on application to the Medical Superintendent, 22, *Chenies Street*,
Gower Street, W.C.

PLASMON

USES IN DISEASE.

This Natural Milk Proteid, Highly Nutritious, Easily Digested, and Readily Assimilated Food, is intended for Infants and Adults whose digestive functions are impaired by illness or senile decay. Rich in Albumins and Phosphates of Lime, Iron, Sodium and Potassium, it forms an ideal food for the repair of Tissues—whether, Muscle, Nerve or Bone.

In the Dietary of Typhoid and other Fever Patients, Plasmon takes a very high place and is preferred to milk by many. It does not form a heavy clot like milk, and the green appearance of the stools soon disappears.

It does not in any way increase the temperature; by maintaining the Nitrogen equilibrium it has the reverse effect.

In the Treatment of Consumption, Plasmon will be found to be an ideal food by reason of its highly nitrogenous value and its digestible nature. It does not nauseate the patient, as 3 or 4 lbs. of beef steak, or 6 to 8 pints of milk per day would—one tea-spoonful of Plasmon being equivalent to 4 ounces of beef steak, or 1½ pints of milk, in nutrient value.

In Strumous, Marasmic, and other Tubercular affections, Plasmon forms a food that produces most favourable results. Very marked effects are obtained in Rickets, and other Bone disorders, the Salts of Milk supplying all that is necessary for the development of healthy bone tissue.

In cases of Peritonitis and such like abdominal affections, Plasmon will be found very useful, as it is almost entirely absorbed, and causes no irritation along the alimentary tract. In cases of abdominal surgery where absolute rest is required for the bowels Plasmon forms an ideal diet.

In Neurasthenia and cases of Multiple Neuritis, Plasmon, as a Food and Therapeutic Agent, is held in very high esteem. Plasmon has very powerful action on the Nerve Tissues, supplying the Phosphorus necessary for the building up of healthy nerve cells. It is perfectly soluble, forming a neutral solution.

*SAMPLES, together with MEDICAL EVIDENCE & MEDICAL PRESS REPORTS,
Free of Charge, sent to Medical Men and Nurses only.*

PRICES: Plasmon Granulated Powder—

| | | | | | | |
|------------|----|----|----|----|----|-----------------|
| Small size | .. | .. | .. | .. | .. | 9d. per packet. |
| Medium „ | .. | .. | .. | .. | .. | 1s. 4d. „ |
| Large „ | .. | .. | .. | .. | .. | 2s. 6d. „ |

The Plasmon Syndicate, Ltd.,

56, Duke Street, Grosvenor Square, LONDON, W.

Concise yet comprehensive summaries of all in periodical literature important to the practitioner. Facts, not mere opinions, characterise the "Review," instead of the commonplace remarks and indiscriminate and useless notices of crude and unproved views which constitute many so called "Epitomes."

The Medical Review

(MEDICAL AND SURGICAL REVIEW OF REVIEWS.)

AN INDEXED AND ILLUSTRATED
MONTHLY RECORD OF ALL THAT IS IMPORTANT TO THE PRACTITIONER IN THE
MEDICAL PERIODICALS IN THE WORLD.

PRINTED IN LARGE CLEAR TYPE, ON SUPERFINE PAPER.

Subscription £1 per annum, post free to any part of the world.

By the suppression of all unessential matter, a paper written with any definite object—and such alone is valuable—can generally be compressed into a comparatively brief report, and yet remain a clear and readable account of the subject, so that nothing of importance is lost, and often, in lucidity, much is gained. Merely to mention a few of the leading features of an article serves no useful purpose.

" . . . A great boon to the profession all over the world. . . . I applaud not only your scheme, but the manner of its execution. . . ."—JONATHAN HUTCHINSON, LL.D., F.R.S., Ex-President of the Royal College of Surgeons, England.

"Extremely useful to the busy practitioner."—*Lancet*.

" . . . I think you are about to fill a very great want. . . ."—T. CLIFFORD ALBUTT, M.A., M.D., F.R.C.P., F.R.S., Regius Prof. of Physic, Cambridge University.

" . . . It would be impossible for such a journal not to take at once a first place. . . ."—*Birmingham Medical Review*.

" . . . Of great value to the general practitioner, and to teachers and authors. . . ."—BYROM BRAMWELL, M.D., F.R.C.P. Edin.

"Destined to the greatest and legitimate success. . . . Well edited. Giving an exact account of all of importance in science and medical practice."—*Journal des Practiciens*.

"The 'Review' brings me into touch with methods and ideas which I could not possibly have otherwise obtained. . . . No surgeon can afford to do without such an excellent index to scientific progress."—J. O'CONOR, M.A., M.D., Senior Medical Officer, British Hospital, Buenos Ayres.

IMPORTANT TO NEW SUBSCRIBERS.

BACK NUMBERS.

The attention of new subscribers is called to the desirability of applying for Vols. I. and II. of the "REVIEW" before they are out of print.

As the important facts recorded in the "REVIEW" are not presented as isolated contributions only, but as collated records, the bound volumes present, in a unique manner, the definite progress of medical science, and render all that is important to the practitioner in the current medical periodicals readily accessible.

Already one of the parts has had to be reprinted, and now only a limited number of Vol. II. is available for new subscribers. The first 500 new subscribers to the "REVIEW" for this current year, who purchase Vol. II. will each be entitled to a bound copy of Vol. I. (Nos. 1, 2 and 3) *free of charge*.

The price for Vol. II., crown 4to, cloth, is 21/- net.

All communications to be addressed to the SECRETARY, Cheques and Postal Orders should be made payable to THE MEDICAL AND SURGICAL "REVIEW OF REVIEWS," LIMITED, 12, Norfolk Street, Strand, London, W.C., and crossed "BROWN, JANSON & Co."

NEW SYDENHAM SOCIETY.

SALE OF SURPLUS VOLUMES.

IN order to reduce its Stock-in-hand, the Society is now offering many of the past Volumes at almost nominal cost. Among them are those of Graves, Niemeyer, Stokes, Trousseau (Vols. i., iv., v.), Charcot, Marie, Spiegelberg, Pozzi, and many others. The Volumes have been re-arranged in Guinea Sets. In some instances as many as Eight Volumes may be obtained for One Guinea. Full Catalogues may be obtained from

MR. H. K. LEWIS, 136, Gower Street, W.C.

The following are the Contents of some of the Sets :—

SET I.—Three Vols.

Two Monographs on Malaria and the Parasites of Malarial Fevers
Laveran on Paludism.
Selected Monographs, Vol. 121, on Malaria, &c.

SET III.—Five Vols.

Binz's Lectures on Pharmacology, 2 Vols.
Naunyn on Cholelithiasis.
Ewald's Disorders of Digestive Organs, 2 Vols.

SET V.—Eight Vols.

The Works of Sir William Gull, 2 Vols.
The Collected Works of Dr. Addison.
Latham's Works, 2 Vols.
Selections from the Works of Colles.
Warburton Begbie's Works.
Graves's Clinical Medicine, 2 Vols.

SET VII.—Six Vols.

Selected Monographs on Dermatology (Unna, Nielsen, Duhring, Bronson, Blanc, Berger, Prince-Morrow).
Essays on Acromegaly (Pierre Marie and Souza Leite).
The Works of Sir William Gull, 2 Vols.
Monographs and Lectures from German Sources, Series iii.
Selected Monographs, Vol. 110.

SET VIII.—Seven Vols.

Billroth's Clinical Surgery (Illustrated).
Essays on Micro-Parasites in Disease. Selected by Watson Cheyne (Illustrated).
Monographs and Lectures from German Sources, Series iii., Vol. 148.
Essays on Acromegaly (Pierre Marie and Souza Leite).
Memoirs on Diphtheria.
Lancereaux's Syphilis, 2 Vols.

SET X.—Eight Vols.

Selected Lectures and Papers from Foreign Sources, Vol. 161.
Naunyn on Cholelithiasis.
Hebra's Diseases of the Skin, Vols. ii., iii., iv. and v.
Griesinger on Mental Pathology.
Niemeyer's Lectures on Pulmonary Consumption.

SET XI.—Seven Vols.

Naunyn on Cholelithiasis.
Stricker's Histology, Human and Comparative, 3 Vols. (Illustrated).
Selections from the Works of Dr. Duchenne.
Koch's Researches on Wound Infection.
Stokes on Diseases of the Chest.

THERE ARE XXIV. SUCH SETS.

Medium 8vo. Cloth lettered. 15s. net. Post Free 16s.

A HANDBOOK OF THE GNATS OR MOSQUITOES.

MAINLY intended for the Use of Students of Tropical Medicine giving the Anatomy and Life History of the Culicidæ, with Tables and a Compilation of the descriptions of over 240 species, and Illustrated with one folding and seven full-page plates, and numerous figures in the text.

By MAJOR GEO. M. GILES, I.M.S., M.B.Lond., F.R.C.S.,

Formerly Naturalist to the Indian Marine Survey.

JOHN BALE, SONS & DANIELSSON, Ltd., 83-89, Gt. Titchfield Street, W.

Demy 8vo. Profusely Illustrated and much enlarged. Price 2s. 6d. net; Post Free, 2s. 8d.

British Sanatoria Annual

BEING A LIST OF ALL THE KNOWN BRITISH SANATORIA

FOR THE

OPEN-AIR TREATMENT OF TUBERCULOSIS.

[Reprinted with additions and alterations from the "West London Medical Journal."]

N.B.—This book will be found invaluable to Medical Men as well as the general public seeking information on the above subject.

JOHN BALE, SONS & DANIELSSON, Ltd. 83-89, Great Titchfield Street, London, W.

PERSONS desiring to communicate with THE LONDON SCHOOL OF TROPICAL MEDICINE should address The Medical Tutor, London School of Tropical Medicine, Seamen's Hospital, Royal Albert Dock, E., or The Secretary, P. Michelli, Esq., Seamen's Hospital, Greenwich, S.E.

THE JOURNAL OF TROPICAL MEDICINE.

A MONTHLY JOURNAL DEVOTED TO MEDICAL, SURGICAL AND GYNÆCOLOGICAL WORK IN THE TROPICS.

Edited by James Cantlie, M.B., F.R.C.S., and W. J. Simpson, M.D., F.R.C.P.

Published by JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield St., London, W.

Subscription, 17/- per annum, payable in advance.

With Illustrations, 808 pages, crown 8vo, 12s. 6d.

AN INDEX OF MEDICINE :

A Manual for the Use of Senior Students and Others,

BY

SEYMOUR TAYLOR, M.D., F.R.C.P.,

Physician to the West London Hospital.

PRESS OPINIONS.

The Lancet.—"Dr. Seymour Taylor may certainly be congratulated on the success of his labours. He has produced exactly what he desired, and the book may confidently be recommended to those for whom it is intended."

The British Medical Journal.—"As a supplement to the larger standard treatises, and so as a means of codifying the knowledge of the more advanced, it will prove invaluable."

London: SMITH, ELDER & CO.

THE STUDENT'S Laryngology Set of Instruments.

Specially designed to meet the requirements of the Classes held
at the Polyclinic and Medical Graduates' College, London.

THIS Set consists of the following Instruments of best quality, and is supplied
either in plain cardboard box or in leather-covered cases as under :—

- Head Mirror, with either band or spectacle frames.
- 3 Laryngeal Mirrors of different sizes, fitting into one metal handle.
- 1 Post Nasal Mirror, in metal handle.
- 2 Laryngeal Mirrors, marked "L," in ivory handle. } For Syphilitic Cases
- 1 Tongue Depressor, marked "L." } (Lues).
- 1 do. do.
- 1 Nasal Speculum.
- 1 Set of 3 Aural Specula.
- 1 Flexible Probe.
- 1 Pair of Dressing Forceps.

Price, Complete in Cardboard Box, £2 10s. net, or in leather-covered Case
with Catch, 9s. extra.

Forceps for Peritonsillar Abscess

(Suggested by Dr. StClair Thomson).



THESE Forceps are a slight modification of Lord Lister's Sinus Forceps. Being intended chiefly for use in the Throat and Nose, they have been made with a crank handle, so that the field of operation is not concealed by the surgeon's hand. They will be found particularly useful for opening peritonsillar abscesses. When the abscess is pointing, generally at the upper end of the tonsil, firm pressure with the extremity of the Forceps will readily detect the site of suppuration and with slight increase in force the point can be made to penetrate the abscess easily. In withdrawing them the two blades should be separated as in Hilton's method.

The Forceps are also very useful in removing foreign bodies from the nose.

Price, Nickel-plated, 5s. 6d. each, or with Aseptic Joint, 6s. 6d.

ALLEN & HANBURY'S, Ltd.,

Surgical Instrument Manufacturers,

Surgical Instrument Department : 48, WIGMORE STREET, W.

CITY HOUSE :

INSTRUMENT FACTORY :

PLOUGH COURT, LOMBARD STREET, E.C. 59, WEYMOUTH STREET, W.

LONDON.

JOHN BALE, SONS & DANIELSSON, LTD., 83-89, Great Titchfield Street, Oxford Street, W.



